Aids-Hilfe Schweiz
Aide Suisse contre le Sida
Aiuto Aids Svizzero

EMIS2024
EUROPEAN
MEN-WHO-HAVE-SEX-WITH-MEN
AND TRANS PEOPLE
INTERNET SURVEY

EMIS-2024 Switzerland

National Report

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Chapter 1: Introduction

EMIS-2024 is 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/UK/IL). Team Maastricht: Prof. Dr. Kai J. Jonas (co-principal investigator), Liana Aphami (data coordinator), Jules L. Casalini (trans sub-survey coordinator). Team RKI: Dr. Ulrich Marcus (co-principal investigator), Dr. Nikolay Lunchenkov (coordinator EECA), Dr. Barbara Gunsenheimer-Bartmeier. EMIS-2024 was backed by a large consortium of funders and collaborators as described in more detail below. EMIS-2024 in Switzerland was coordinated by Marc Eggenberger (Swiss AIDS Federation).

EMIS-2024 was conceived as a large-scale partnership, with a strong emphasis on involving organisations and representatives of affected communities in the study's design and recruitment. Each step of the process engaged the EMIS Network, drawing on its collective knowledge and needs.

In addition to generating data from MSM, EMIS-2024 aimed to include trans and non-binary individuals more broadly, build research capacity, transfer knowledge about online surveys, generate datasets in countries with fewer resources, facilitate dialogue between community, academic, and public health, and maximise the educational impact of survey completion.

A key benefit of EMIS has been the availability of the questionnaire in all (with the exception of Gaelic Irish) official EEA languages, crucial for countries with large proportions of migrants from southern, eastern, or south-eastern Europe. For the same reason we also provided the survey in Arabic, as it has been the most common languages among refugees coming to Europe since 2014.

The following list acknowledges all EMIS partners by country. Individual names are included when a freelancer served as the main contact or contributed to questionnaire development without formal organisational representation. The order is: main NGO partner, other NGO partners, academic partners, governmental partners, and individuals.

Europe: Grindr for Equality, Grindr, ROMEO, Hornet, Aids Action Europe, European AIDS Treatment Group, Eurasian Coalition on Health, Rights, Gender and Sexual Diversity (ECOM), South Eastern Europe Regional TB and HIV Community Network (SEE RCN).

AL: Albanian Association of PLWHA. **AM:** New Generation Humanitarian NGO. **AT:** *Aids Hilfe Wien*. **BA:** Partnerships in Health. **BE:** Sensoa, Exaequo, Sciensano. **BG:** GLAS Foundation. **CH:** Swiss AIDS Federation, Swiss Federal Office of Public Health. **CY:** AIDS Solidarity Movement, Christos Krasidis. **CZ:** *Česká společnost AIDS pomoc*. **DE:** *Deutsche AIDS-Hilfe*, Robert Koch Institute, IWWIT. **DK:** *Statens Serum Institut*, Dr. Susan Cowan, Dr. Maria Wessmann. **EE:** Estonia National Institute for Health Development, Dr. Kristi Rüütel, Dr. Sigrid Vorobjov. **ES:** SEISIDA, STOPSIDA, CEEISCAT, *Ministerio de Sanidad*. **FI:** *Positiiviset ry*. **GE:** Equality Movement. **GR:** Positive Voice. **HR:** Iskorak, Zoran Dominković. **HU:** Háttér Society. **IE:** EMIS-2024 Ireland Promotion Sub-Committee, Health Service Executive, Mick Quinlan. **IL:** Israel AIDS Task Force, Ministry of Health, Prof. Zohar Mor. **IT:** Fondazione LILA Milano ONLUS, University of Verona. **KZ:** Global Health Research Center of Central Asia (GHRCCA), Human Health Institute, Public Fund "Community Friends". **LT:** Demetra, National Public Health Center. **LV:** AGIHAS. **LU:** *Ministère de la Santé et de la Sécurité sociale*. **MD:** GENDERDOC-M Information Centre. **ME:** Cazas – Montenegrin Association against AIDS. **MK:** Stronger Together (Association for Support of People Living with HIV, Zaedno Posilni). **MT:** HIV Malta, Infectious Disease Prevention and Control Unit. **NL:** SOAids, Maastricht University, RIVM; **NO:** *Helseutvalget*, University of Tromsø –The Artic University of Norway, Norwegian Institute of Public Health, Prof. Rigmor C. Berg. **PL:** *Fundacja Edukacji Społecznej*, Iwona Wawer; **PT:** GAT Portugal*, Instituto de Saúde Pública da Universidade do Porto*, Portuguese Directorate-General of Health. **RO:** ARAS, Tudor Kovacs. **RS:** TOC – Association for the Development of Sustainable Communities; Institute of Public Health of Serbia, Sladjana Baros. **SE:** RFSL, *Folkhålsomyndigheten*. **SI:** LEGEBITRA, ŠKUC. **SK:** Pride Kosice. **TR:** Sami Sarper Yazıcılaroğlu. **UA:** Alliance for Public Health, Alliance Global. **XK:** LGBTI Equal Rights Association for Western Balkans and Turkey. **Other:** Sigma Research, London School of Hygiene & Tropical Medicine.

The approach to working with these organisations varied between the Eastern and Western regions (as defined below), depending on local possibilities, requirements, and the complexity of organisational and legal settings. The large number of partners required flexibility from the investigators and coordinators in structuring and operating the collaboration.

Funding of EMIS-2024

The funding structure for EMIS-2024 was developed in collaboration with the implementing partners—German AIDS Federation (DAH), Maastricht University, and Robert Koch Institute (RKI) between March 2022 and August 2023. The following organisations contributed financially to EMIS-2024:

German Ministry of Health (*Bundesministerium für Gesundheit*, **DE**) / Global Health Protection Programme (GHPP, **DE**); European Centre for Disease Prevention and Control (ECDC, **EU**); Swiss AIDS Federation, Swiss Federal Office of Public Health (**CH**); Luxembourg Health Directorate (*Ministère de la Santé et de la Sécurité sociale*, **LU**); Norwegian Directorate of Health (*Helsedirektoratet*, **NO**); The Public Health Agency of Sweden (*Folkhälsomyndigheten*, **SE**); Sciensano (*Institut Scientifique de Santé Publique*, **BE**); Estonian Ministry of Social Affairs (*Sotsiaalministeerium*, **EE**); Health Service Executive (**IE**); Portuguese Directorate-General of Health (*Direção-Geral da Saúde*, **PT**); Spanish Ministry of Health (*Ministerio de Sanidad*, **ES**); Central Health Department, Israeli Ministry of Health (משרד הבריאות, **IL**); National Institute for Public Health and the Environment (RIVM) */ SOAids Nederland* (**NL**).

Funding for conducting the online survey in Germany was provided by the German Federal Ministry of Health and granted to RKI and DAH. Data collection in the Western Balkans and in Eastern European/Central Asian countries (except Belarus and Russia) was supported through a grant to RKI from the Global Health Protection Programme (GHPP), which is also funded by the German Federal Ministry of Health.

All other financial contributions and contractual arrangements were based on a standard contract template with minor adaptations to accommodate the specific needs and capacities of each partner.

The three co-principal investigators — **Kai J. Jonas**, **Ulrich Marcus** and **Axel J. Schmidt** — initiated the third wave of EMIS and led the design and implementation of the questionnaire. **Liana Aphami** managed the online surveys and the resulting multilingual databases, led data cleaning and labelling, co-authored the variable manual, produced all tables, including the regional breakdown, and led on markdowns for chapters 2, 6, and 8. **Tamás Bereczky** coordinated the survey across 38 countries in the Western Region; managed contracts, translations, and promotion efforts—including those involving G4E and ROMEO; translated the questionnaire into Hungarian; co-authored the variable manual; and co-drafted the initial manuscript of this report. **Jules L. Casalini** led on the trans sub-study and its associated outreach, and led on chapter 8. **Nikolay Lunchenkov** coordinated survey promotion across 12 countries in the Eastern Region, updated the Russian translation, and supported scripting for figures, ECDC indicators, and markdowns for chapters 4 and 5. **KJJ** led the ethics approval process and data contracting and assumed responsibility for legal matters related to the survey. **UM** led recruitment via Hornet, contributed to recruitment via Grindr, and led on chapters 4 and 5. **AJS** coordinated the German translation, participated in data cleaning and management, co-authored the variable manual, coordinated R-scripting and -architecture across the three core institutions, served as the main liaison with ECDC, produced all maps, led on chapters 3, 7, and 9, and finalised the EMIS-2024 National Report Switzerland. **Marc Eggenberger** coordinated EMIS-2024 in Switzerland and supported figure programming and layout for the Swiss report. All analyses and Markdown compilation were conducted using **R v.4.5.1**. Shapefiles for the Swiss maps were kindly provided by the **Swiss Federal Office of Public Health**.

This report and all other EMIS-2024 publications are available at: www.emis-project.eu

Chapter 2: Survey Design and Methods

The complete survey design and methodology can be found in the EMIS-2024 methods paper [1].

2.1 Overview

Questionnaire design – the questionnaire was built on the foundations established from a previous version of the survey (EMIS-2017). The core questions and variables of EMIS have remained consistent from 2010 to 2017 to 2024. In EMIS-2024, a sub-study was developed specifically to meet the needs of trans and non-binary individuals. This sub-study was the result of a modification of the original EMIS questionnaires from 2010 and 2017, following an adaptation of the overall item language and terminology to be inclusive of all trans bodies. Additionally, several trans-specific items were added to investigate experiences unique to the trans community.

Final questionnaire content – the final version included:

- Demographics: 28 descriptive items
- Morbidities: 17 items concerning health outcomes
- Behaviour: 85 items concerning people's actions
- Needs: 23 items or sets of needs-related items relating to opportunities, capabilities and motivations for risk and precaution behaviour
- Interventions: 45 items or sets of items on the actions of others that meet or undermine needs

Translation and online preparation – after translation from English and checking by partners, online versions were checked for structural homogeneity. National partners confirmed the terminology fitted with their perceptions of the norm for the target group in their country, reviewed the final survey, and signed off their main language version. The survey was available in 35 languages.

Online recruitment – online recruitment operated on different timelines and strategies across regions. The survey was open for submissions for six months from 22 December 2023 to 30 June 2024. Country leads coordinated national advertising including the number, size and specification of promotional materials. The core team commissioned advertising through dating platforms.

Final sample – the narrative element of this report is based on 50 330 respondents, including 3516 individuals with sex assigned at birth different from their reported gender identity (including non-binary gender identity), of which 2658 (75.6 %) identified as part of the trans community, living in 46 countries (all 29 EU/EEA, three from the non-EEA advanced economies, seven from the Western Balkans and Türkiye, seven from Eastern Europe and Central Asia).

Duration - The average completion time was 30 minutes.

Country-specific findings – Chapters 3–8 present the key findings in tables by country of residence at the end of the chapter, with countries are presented alphabetically in the four primary country groupings listed above. Key variation between the residents of specific countries is also illustrated in maps throughout the report.

Ethics approval was granted by the Ethics Review Committee Psychology and Neuroscience of Maastricht University (reference ERCPN-OZL_262_08_01_2023) on the 30th of October 2023.

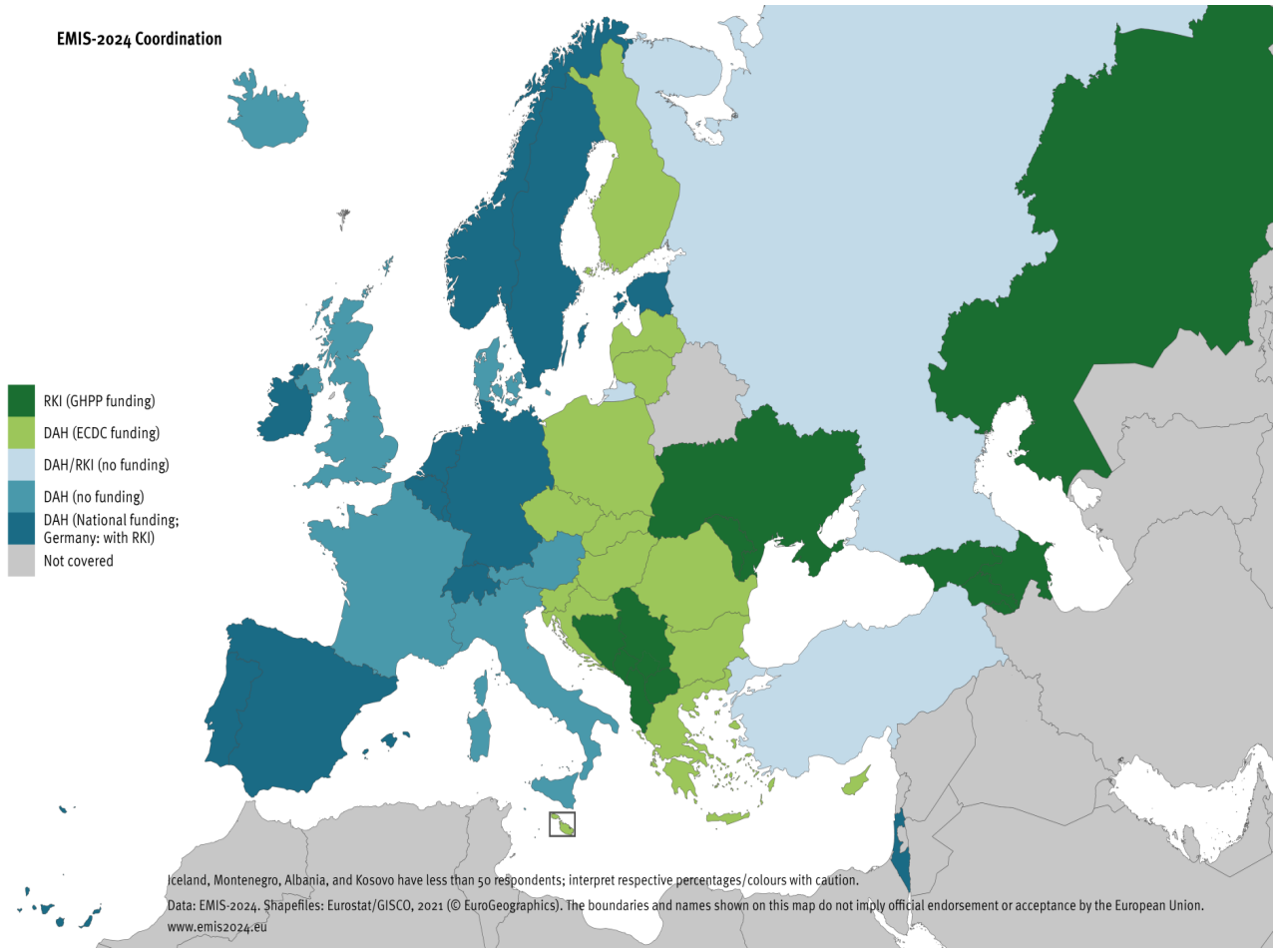
2.2 Countries participating in EMIS-2024

At a minimum, we sought to recruit 100 people residing in 46 countries where funding existed for the translation of the survey and its promotion. These 46 countries included all 29 EU/EEA states, three from the non-EEA advanced economies, seven of the Western Balkans and Türkiye, seven of from Eastern Europe and Central Asia.

We did not exclude residents of the four non-EU European microstates that adjoin or are encompassed by larger countries already included in the sample. Although we did not expect to recruit a viable sample in these microstates, we included respondents living in them in the dataset for adjoining or encompassing countries – Andorra with Spain; Liechtenstein with Switzerland; Monaco with France and San Marino with Italy.

Unlike previous EMIS waves, EMIS-2024 had a more complex funding and operational structure due to political circumstances, including the wars in Russia and Ukraine, and Israel/Gaza. The geographical scope was thus divided into two regions: Eastern and Western, with distinct timeline and recruitment strategies.

Map 2.1: EMIS-2024 coordination and funding



Countries receiving national funding are shown in dark blue, those in lighter blue were included without funding as their languages were already covered. Countries co-funded by ECDC are highlighted in light green, and those funded by Germany's Global Health Protection Programme (GHPP) are in dark green. EMIS-2024 was coordinated by DAH and RKI, as illustrated in **Map 1**. Belarus and Lebanon were part of previous EMIS waves but not included in EMIS-2024, mostly due to a lack of national partners.

Western Region

DAH was responsible for the organisational, financial, and contractual arrangements in the Western region, which included EEA countries, as well as Israel, Switzerland, the UK, the four microstates, Türkiye and Russia. RKI supported survey coordination in Germany, as well as translation and recruitment activities in Russia and Turkey. Coordination in Russia was additionally supported by the University of Tromsø — The Arctic University of Norway. Formal agreements were established with NGOs and community organisations in the region to carry out translations and support recruitment efforts. Each organisation was compensated with a standard fee for its contributions.

Eastern Region

RKI managed the organisational, financial, and contractual arrangements in the Eastern Region, which included the Western Balkans, Eastern Europe and parts of Central Asia. GHPP funding supported translations and survey promotion in this region, but did not include Uzbekistan, Turkmenistan, Kyrgyzstan and Tajikistan — limiting Central Asian participation to Kazakhstan. RKI subcontracted ECOM (for Armenia, Azerbaijan, Georgia, Kazakhstan, Moldova, and Ukraine) and SEE RCN (for the Western Balkans) to coordinate activities, drawing on their regional expertise and strong HIV/STI prevention networks.

2.3 Designing the questionnaire

The primary aim of this study was to replicate the EMIS survey seven years after its implementation in 2017, which was also a reiteration of EMIS-2010. Building on the foundations established for EMIS-2017, the EMIS-2024 questionnaire aimed to generate crucial data for the planning and monitoring of interventions related to HIV, STIs, and viral hepatitis. The core questions and variables of EMIS have remained consistent from 2010 to 2017 to 2024. While no formal tender was issued, we were committed to maintaining the survey's focus on the specific needs of MSM. Rather than creating a generalized health survey, we sought to expand the scope of the original survey to address evolving trends and emerging needs within the community, particularly for transgender individuals, who often face unique challenges and disparities in sexual health, in order to better understand their needs and experiences. A significant challenge in traditional HIV surveillance has been the grouping of transgender individuals with MSM, which obscures their unique vulnerabilities. To address this issue, we aimed to disaggregate data between transgender individuals and MSM, as well as between trans individuals assigned female at birth and trans individuals assigned male at birth.

To achieve this, filters were employed and customized questions were formulated that corresponded to participants' choices, ensuring the data collected were both relevant and respectful of individual experiences. The overall goal of this study was to generate data that would inform the planning of effective HIV and STI prevention and treatment interventions. This involved assessing the prevalence and distribution of HIV/STI-related morbidities, identifying associated risk and precautionary behaviours, and understanding the specific prevention needs and interventions required. To provide a comprehensive understanding of sexual health, we adopted a holistic approach that considers the interconnectedness of HIV/STIs, substance use, and mental health. This approach aligns with the work of our collaborators who focus on these three health outcomes.

In EMIS-2024, we included a sub-study specifically tailored to the needs of trans and non-binary individuals. This sub-study was the result of a modification of the original EMIS questionnaires from 2010 and 2017, following an adaptation of the overall item language and terminology to be inclusive of all trans bodies. On top of the original questionnaire, several trans-specific items were added to investigate experiences unique to the trans community.

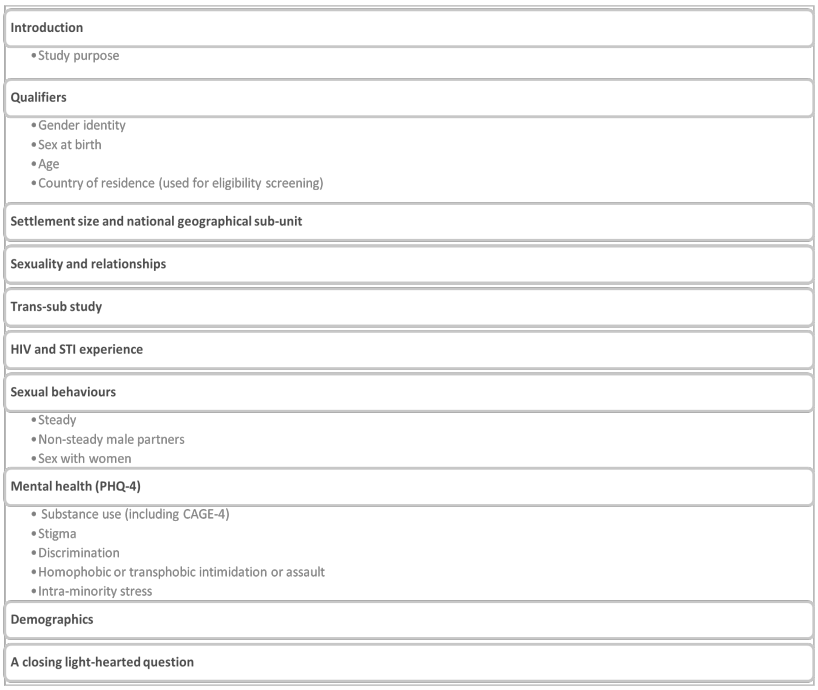
A further tension in the survey design was between many concepts measured simply (a single question to measure it), and a few others measured more precisely (with each concept requiring multiple questions). Our collaborative approach to survey design meant there were many concepts (issues, concerns, questions) for inclusion. Event-based questions used a recency format where participants are asked *"When did you last X?"* and offered a range of increasing periods in the past. The recency format gives a sense of the density of an activity in the population. The final questionnaire allows for the generation of ECDC [2] indicators related to HIV/STIs among MSM. We collaborated with ECDC to decide which indicators could be constructed using EMIS-2024 variables.

The final questionnaire sought 321 different data items from respondents; however, it was tailored with question filters (routing) wherever possible (for example, only participants with a steady partner were asked how long they had been in a relationship). The final English language questionnaire formed the basis for the EMIS-2024 ethics application.

Structure of the questionnaire

The questionnaire is divided into several key sections to address diverse topics, as illustrated in **Figure 2.1**.

Figure 2.1 Sections of the questionnaire



The final questionnaire's content was organised into five conceptual layers. **Figure 2.2** providing a visual overview of these layers.

Demographics

28 descriptive items about people that we are not trying to change, all of which are described in **Chapter 3** and in **Section 8.1** (specifically for the four transgender groups).

Morbidities

17 items concerning health outcomes that we are trying to change, all of which are described in **Chapter 4** and in **Section 8.2** (specifically for the four transgender groups).

Behaviours

85 items concerning acts that generate risks or detract from precautions, all of which are described in **Chapter 5** and in **Section 8.3** (specifically for the four transgender groups).

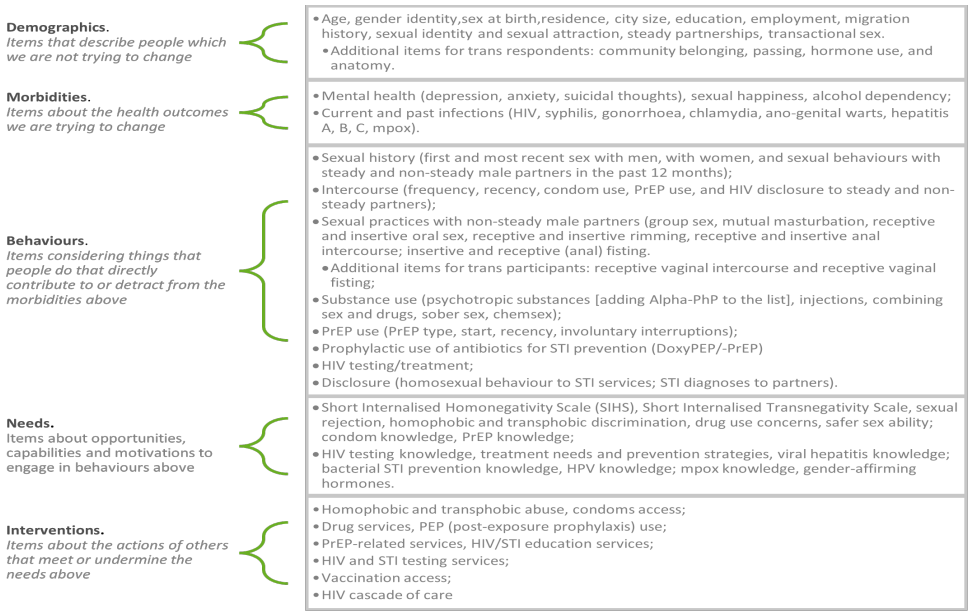
Needs

23 items or sets of needs-related items that concern opportunities, capabilities and motivations for risk and precaution behaviour, all of which are described in **Chapter 6** and in **Section 8.4** (specifically for the four transgender groups).

Interventions

45 items or sets of items on the actions of others that meet or undermine needs, all of which are described in **Chapter 7** and in **Section 8.5** (specifically for the four transgender groups).

Figure 2.2 Conceptual layers of the questionnaire



2.4 Translations

Partnerships within the EMIS Network facilitated the translation process. Translators from the 33 core countries (excluding the UK and Ireland) were provided with payment options, but only a part of them chose to accept the compensation. National partners checked the translated versions for routing across questions, and the study team checked that the data were saved in an identical format across all languages.

Ultimately, the survey was available in 35 languages, Albanian, Arabic; Armenian, Azeri, Bosnian/Croatian/Montenegrin/Serbian, Bulgarian, Czech, Danish, Dutch, English, Estonian, Finnish, French, Georgian, German, Greek, Hebrew, Hungarian, Italian, Kazakh, Latvian, Lithuanian, Macedonian, Malti, Norwegian, Polish, Portuguese, Romanian, Russian, Slovak, Slovenian, Spanish, Swedish, Turkish, and Ukrainian.

2.5 Recruitment

Recruitment settings

EMIS-2024 was promoted by advertising on:

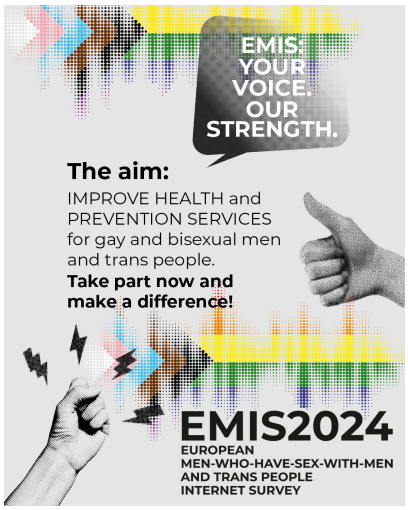
(1) websites of supporting organisations (national/trans-national, public/commercial/NGOs HIV/LGBT organisations, etc.), including social networking sites (such as Facebook, Instagram…)

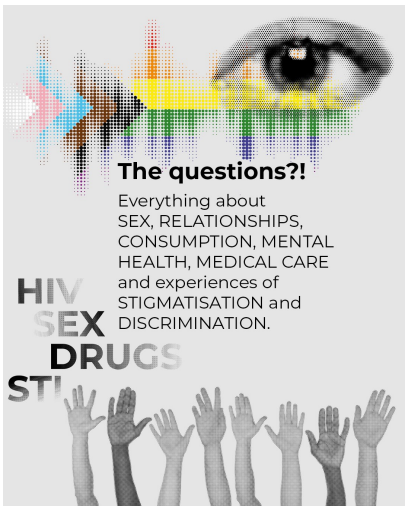
In Switzerland, 45.3 % of respondents were recruited by this method (Map 2.2).

(2) MSM targeted smartphone dating apps and web applications.

In Switzerland, Grindr/Grindr4Equality recruited 28.0 % of respondents, ROMEO recruited 26.7 %.

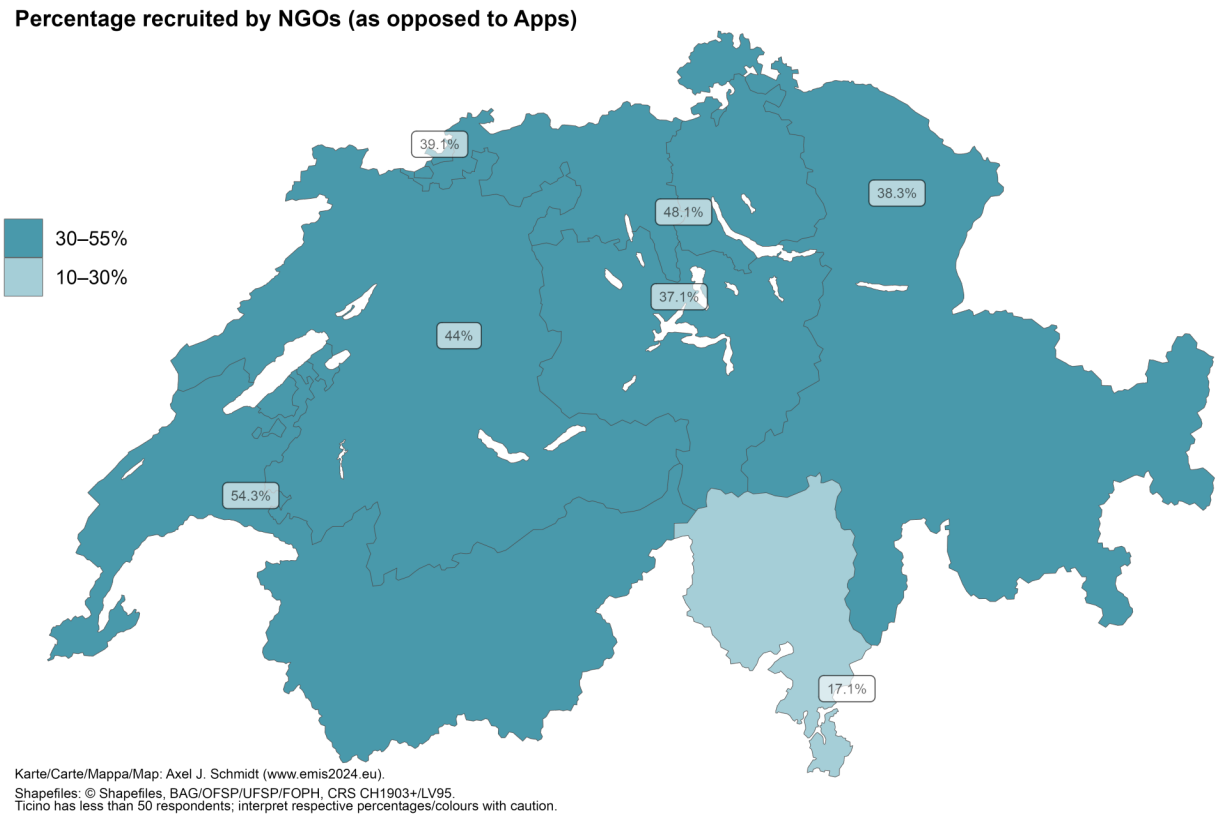
Promotional materials





A standard visual identity for EMIS-2024 was developed by an external consultant. The different elements of the visual identity were distributed to all recruiting organisations and individuals online and free of charge, encouraging them to "mix and match" these elements according to their local needs and possibilities. The core tagline in English was *"Your voice – our strength!".* National partners could use the translation or adaptation on this text depending on their local contexts.

Map 2.2: Percentage recruited by NGOs



2.6 Total returns and non-qualifiers

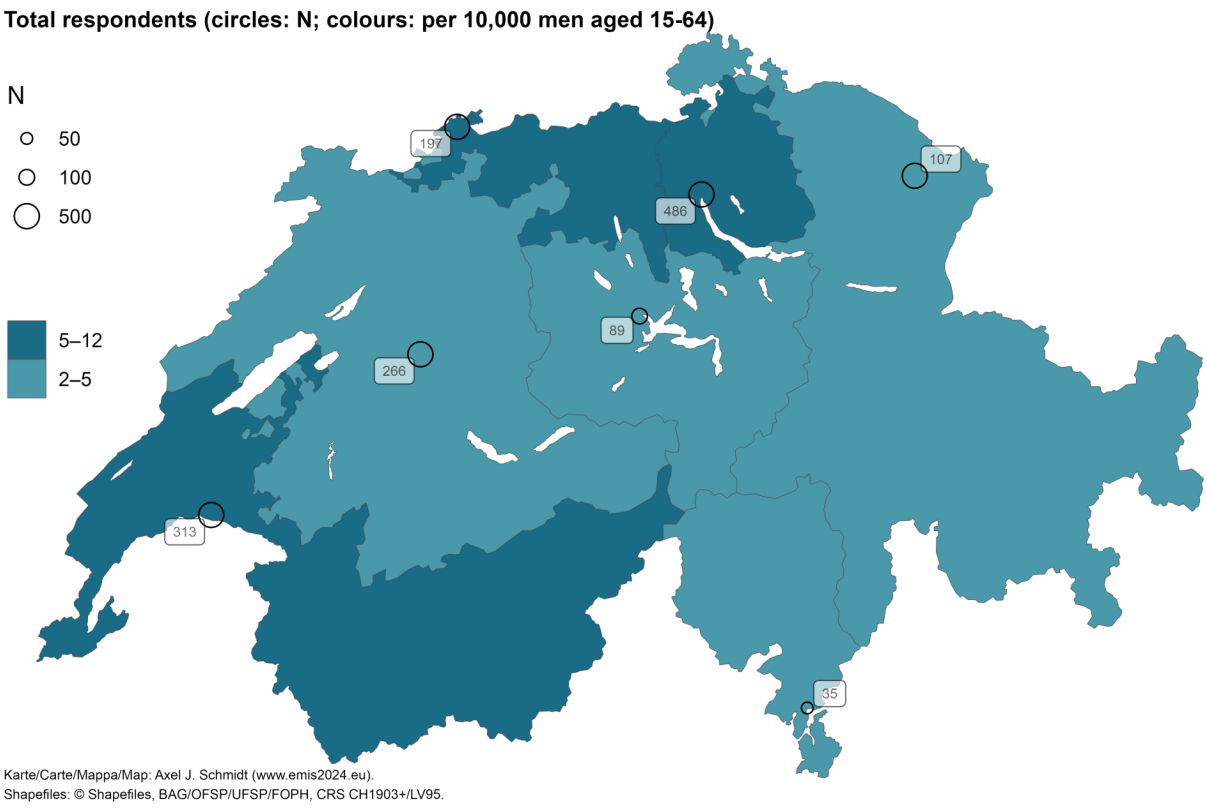
The survey was accessible to all eligible participants, while those who did not meet the criteria (based on country and gender identity) received a prompt to either continue or exit. Any non-qualifying respondents who proceeded were later excluded during data cleaning.

The data cleaning process followed four key steps:

- **Step 1** – Handling missing data
    - Excluded respondents with less than 95 % completion
    - Removed duplicate submissions
    - Excluded participants who did not provide consent
    - Eliminated entries missing required responses for gender identity, sex assigned at birth, or age.
- **Step 2** – Removing non-eligible respondents
    - Cisgender women
    - Individuals outside the designated countries
    - Men, trans, or non-binary individuals without experience or interest in sex with men
    - Persons less than 16 years of age (less than 17 year in Ireland and Cyprus, and less than 18 years in Türkiye).
- **Step 3** – Exclusion of respondents with highly discrepant responses
- **Step 4** – Controlling for the duration of responses (in seconds) to identify too short response times that might suggest disingenuous data.

At the conclusion of fieldwork, the dataset contained 50 330 cases, **including 1509 cases from Switzerland**. **Map 2.3** shows the number of respondents and crude recruitment rate across Switzerland. Recruitment rates were calculated by dividing the number of qualifying cases by the estimated male population aged 15–64.

Map 2.3: Number of respondents and crude recruitment rate per region



2.6 Datasets

The data were divided into national datasets based on current country of residence, regardless of the language used to complete the survey or country of birth; and were also combined into a pan-European dataset. National datasets are available for all 42 countries with 50 or more qualifying cases. Eight countries did not reach 50 qualifying cases. For the three smallest of these countries, because a viable sample size was never expected, cases are included in the datasets of adjoining or surrounding countries:

- Andorra (9 cases) – included in the Spain dataset.
- Liechtenstein (4 cases) – included in the Switzerland dataset.
- Monaco (2 cases) – included in the France dataset.
- San Marino (0 cases) – in previous waves included in the Italy dataset.

No national datasets can be provided due to too low participant numbers (fewer than 50 respondents) for the following countries:

- Albania (32 cases)
- Iceland (18 cases)
- Montenegro (22 cases)
- Kosovo* (5 cases)

2.7 Statistical approach

In this report our approach to data presentation is descriptive rather than statistical. Each section in **Chapter 3 to 7** describes the questions asked and provides the responses received. EMIS is a non-probability sample; therefore, it is inappropriate to calculate confidence intervals (based on standard sampling error) for measures. To increase readability in the narrative of the report, no decimal places are used for percentages, except when the figure is less than 2 %.

Chapter 9 cross-tabulates responses to key demographic questions with other indicators. The primary purpose here is to provide the indicators for sub-groups of concern. We have not calculated the probabilities of the differences observed as random since this is a non-probability sample. We have not provided unadjusted associations (e.g. odds ratios, risk ratios) between the demographic target groups and the indicators as these can be calculated from the data in the tables. We have not provided adjusted associations between the demographic target groups and the indicators (*i.e.*, checking for membership of the other demographics target groups) as we are not asking questions about the causality of these associations but describing the levels of the many indicators in the myriad target groups.

In all tables, where the denominator for a cell is less than 20 (for example, a measure among men with diagnosed HIV in a country with a small overall sample size and lower prevalence of diagnosed HIV), the figure is not supplied, but instead the cell contains the characters ‘n<20’.

References

1. Aphami L, Bereczky T, Casalini JL, Lunchenkov N, Marcus U, Jonas KJ, Schmidt AJ. European Men-Who-Have-Sex-With-Men Internet Survey (EMIS-2024): Design and Methods. Sexuality Research and Social Policy. 2025; Under Review. Preprint available. Available from: https://doi.org/10.21203/rs.3.rs-6991809/v1

2. ECDC. Dublin Declaration Monitoring 2024. European Centre for Disease Prevention and Control; 2024 [cited 2025 Sep 5]. Available from: https://www.ecdc.europa.eu/sites/default/files/documents/2024DDSurvey-EN_Final_2024FEB07.pdf

Chapter 3: Demographics

The variables reported in this chapter relate to characteristics of the Swiss respondents and their situation that HIV/STI and health promotion programmes cannot change or are not usually trying to change. In other words, there is no 'preferred' response to the questions, although some programmes may have outcome targets related to these characteristics (for example, reducing harm related to sex work).

From the perspective of sexual health promotion, the characteristics reported in **Chapters 3–7** describe everyone invited to take part in EMIS-2024: Sexual minorities at increased risk for HIV and STIs—mainly men who have sex with men (MSM, cis and trans) but also trans women and non-binary individuals who have sex with men.

Chapter 8 provides a more detailed comparison among four transgender groups. The way in which morbidities, risk and precaution behaviour, health promotion needs, and experience of interventions vary across these characteristics is reported in **Chapter 9**. For a description of how these characteristics vary by country of residence see **Section 3.9**.

3.1 Sex at birth and current gender identity

Gender identity and sex assigned at birth were part of the qualifying conditions for taking part in the survey (therefore, there is no missing data for this variable). All respondents were asked, *"What is your current gender identity?"* and were offered the responses: man; woman; and non-binary, followed by a question regarding their sex assigned at birth (with options male; or female). Of the 1509 respondents in the final Swiss sample, the majority of respondents were cisgender men, (N = 1396, 98.1 %), followed by non-binary (n = 74, 4.9 %).

Table 3.1 below shows the associations between responses to these two questions. **Section 3.9** shows country variation in the percentage that were assigned female sex at birth.

Table 3.1 Current gender identity by sex assigned at birth (row percentages)

Gender identity by sex assigned at birth	n	% assigned male at birth	% assigned female at birth
Man	1 423	98.1	1.9
Woman	12	0.8	-
Non-binary	74	54.1	45.9

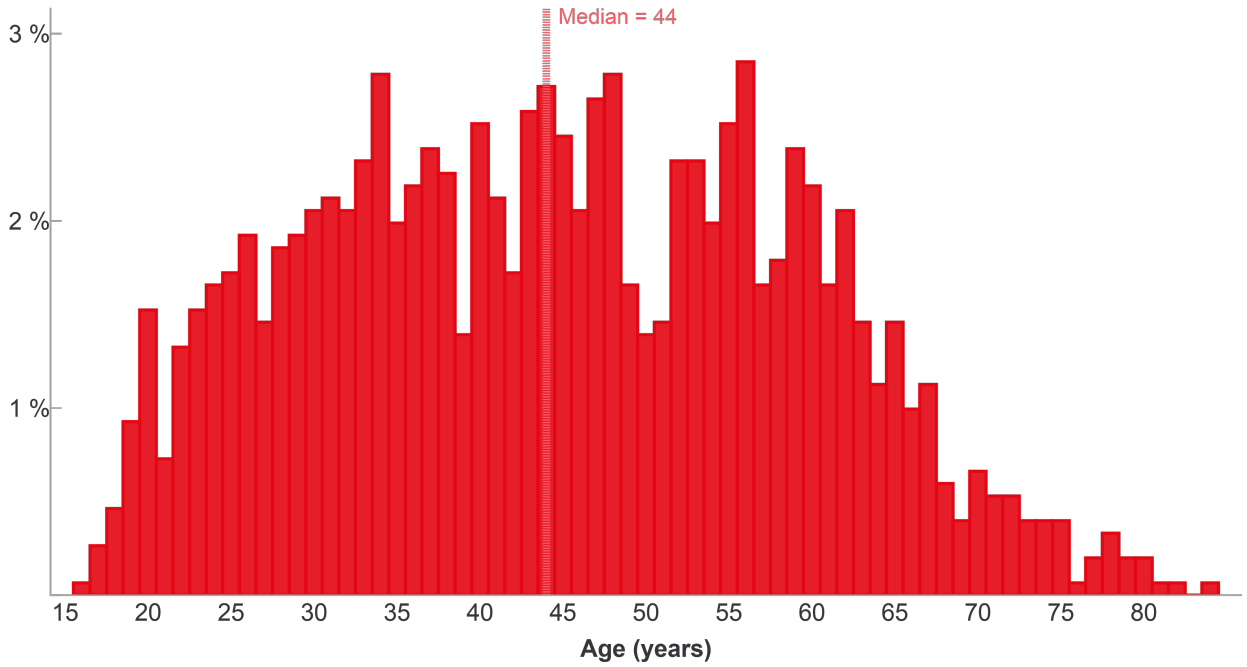
3.2 Age

Providing an age was a qualifying condition for the survey. Unlike in previous EMIS waves, where everyone being of or above the age of consent for sex with respondents in the country of residence was eligible, in EMIS-2024 study participants had to be at least 16 years old to take part—a requirement of Maastricht University. **Figure 3.1** shows the age distribution across the Swiss sample.

Figure 3.1 Age in years across the entire sample (N = 1509)

Figure 3.1: Age distribution of EMIS-2024 respondents (n = 1509) [Switzerland]

The dashed line indicates the median value.



The median age of the Swiss sample was 44 years (interquartile range: 33—56, mean 44.6, standard deviation 14.3). The age profile shows a sharp increase after 16 years, while the right-hand tail was much more skewed.

3.3 Country of residence and settlement size

All participants were asked, *"What country do you live in?"* and were offered a list of countries. Respondents who lived in countries other than those for which EMIS-2024 was collecting data were told *"Unfortunately this survey is not collecting data from the country you live in. You are very welcome to read and complete the rest of the survey, however we will be unable to use your data."* **Table 3.2** shows the region where respondents currently live.

Table 3.2 Region of residence

Place currently living in	n	% of all
Région lémanique	313	20.7
Espace Mittelland	266	17.6
Nordwestschweiz	197	13.1
Zürich	486	32.2
Ostschweiz	107	7.1
Zentralschweiz	89	5.9
Ticino	35	2.3
Liechtenstein	16	1.1
Total	**1 509**	**100**

At the end of **Chapters 3–7**, the key variables for each chapter are presented by region of residence, and a few selected cities were added for completeness: Zürich and—to achieve a sufficiently large sample size and to have a counterpart in the French-speaking part of Switzerland—Geneva and Lausanne combined.

All respondents were asked, *"How would you describe the place you live in?"* and were offered the responses in **Table 3.3**, which also shows the percentage indicating each response.

Table 3.3 Description of the size of settlements where respondents currently live

Size of settlement where respondents currently live N = 1498	% of all*
A village/the countryside (less than 10 000 people)	31.7
A medium-sized city or town (100 000–499 999 people)	30.0
A small city or town (10 000–99 999 people)	28.6
A big city or town (500 000–999 999 people)	9.7
A very big city or town (a million or more people)	-
Total	**100**

* Missing n = 11

3.4 Migration history

Study participants were asked, *"Were you born in <Country Living In>?"* and were offered the responses *"Yes"* or *"No"*. Overall, 28.4 % (N = 1508, missing n = 1) indicated that they were not born in Switzerland. These study participants were asked, *"Which country were you born in?"* and were offered the same list as for the country they lived in. **Table 3.4** summarises responses recoded into continents. Almost all respondents not born in Switzerland were born in another European country (94.5 %).

Table 3.4 Country of birth recoded to continents among whole sample, and those not born in their current country of residence

Country of birth recoded into continents N = 1508	% of all respondents not born in the country they currently live in*
Continental Europe	94.0
Other countries in the WHO European Region: Armenia, Azerbaijan, Cyprus, Georgia, Israel, Kazakhstan, Türkiye; and European overseas territories	0.5
North America (and Caribbean)	1.7
South America	2.4
Africa	0.6
Asia	0.7
Australia & Oceania	0.2
Total	**100**

* Missing n = 1

The EMIS-2024 questionnaire was offered in 35 languages. In Switzerland, the languages used to complete the survey closely reflect the country's linguistic distribution: German (61.5 %), French (21.9 %), Italian (4.2 %, slightly underrepresented), as well as English (8.9 %), Spanish (1 %), and Portuguese (1 %), reflecting the impact of migration.

Map 3.1 illustrates the proportion of respondents born outside Switzerland and highlights the top three countries of birth among direct migrants by region. Across Switzerland, these top three countries of birth closely reflect overall Swiss immigration patterns. In the canton of Zurich, MSM and trans/non-binary individuals from Brazil constituted the third-largest migrant group.

Study participants not born in the country they were living in were also asked, *"How many years have you been living in <Country Living In>?"* Among the 28.4 % of respondents not born in Switzerland, 4.2 % had lived in that country for less than one year, 19.6 % for less than five years and 36.4 % for less than ten years. **Figure 3.2** illustrates the responses.

Map 3.1: Percentage born abroad and top three countries of birth (with N>5) (N = 1508, missing n = 1)

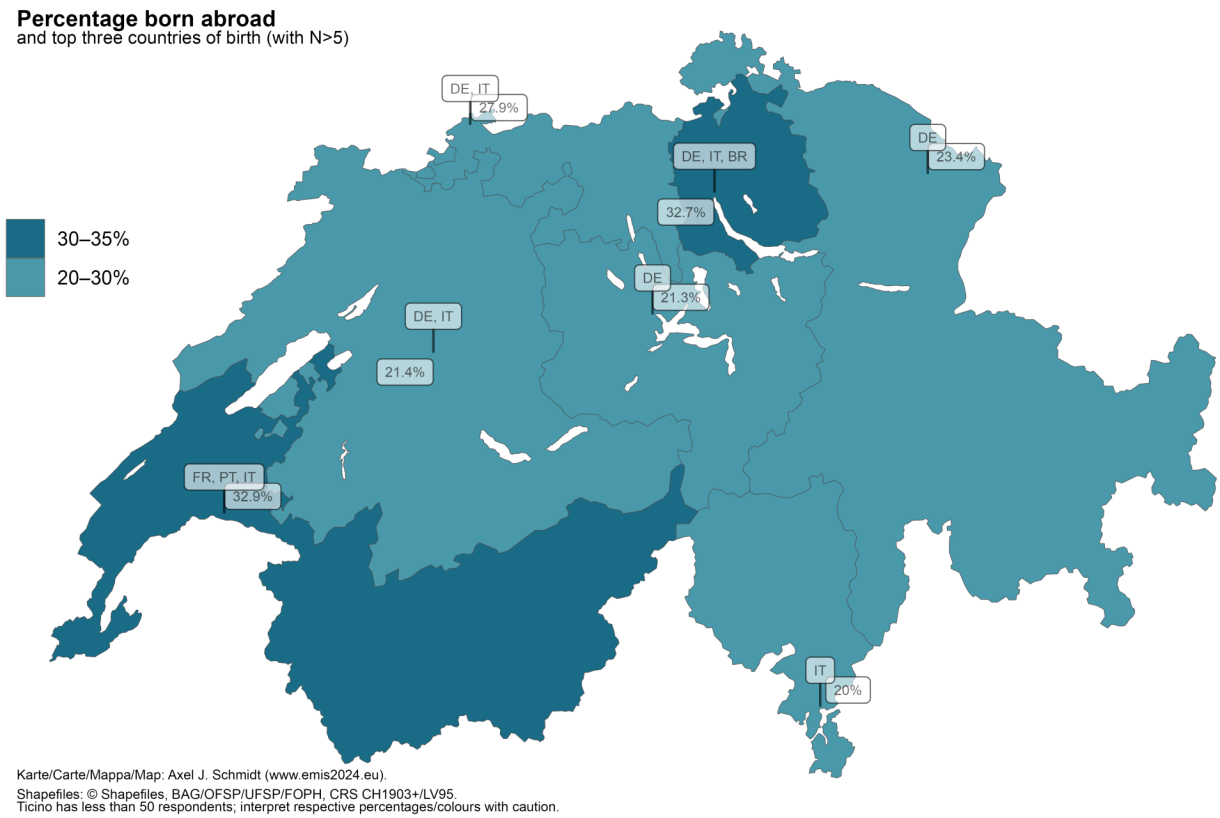
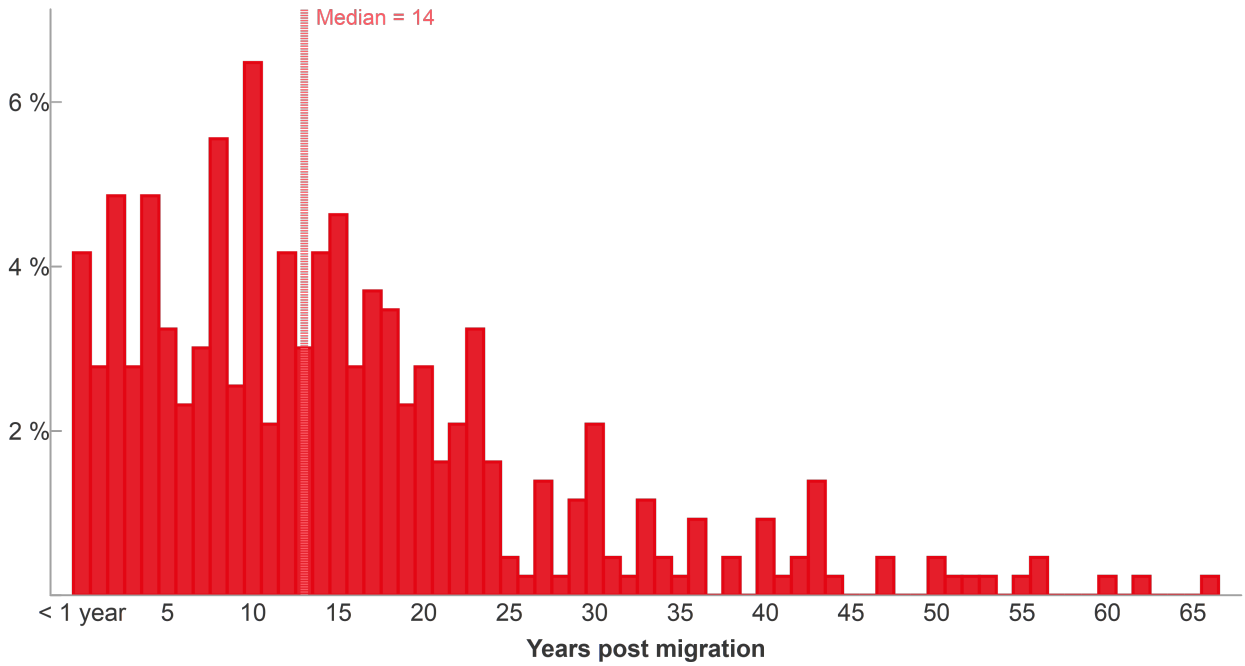


Figure 3.2 Years living in Switzerland post migration

Figure 3.2: Years living in country of residence post migration (n = 432) [Switzerland]

The dashed line indicates the median value.



Study participants not born in Switzerland were asked, *"Why did you come to <country living in>?"* and were offered the responses in **Table 3.5**.

Table 3.5 Reasons for migration among respondents not born in Switzerland

Reason of migration N = 420	% of all*
I was brought as a child	14.8
To study	16.9
To work	68.8
To be with a partner	20.0
To live more openly as gay/bisexual/trans/queer	6.7
To seek asylum	1.7
I came as a refugee	1.0
I was brought against my will	0.5
Other answer	1.0

* Missing n = 15

Work was the most commonly cited reason for coming to Switzerland. Immigrating for work or to study were given as the reasons for migration by 85.7 % of migrant respondents (some ticked both these reasons.

Of the respondents not born in Switzerland, 1.7 % indicated they had come to the country they lived in as a refugee and/or asylum seeker (0.5 % of the entire sample). These respondents (n = 7) are compared with other migrants and non-migrants in **Chapter 9**.

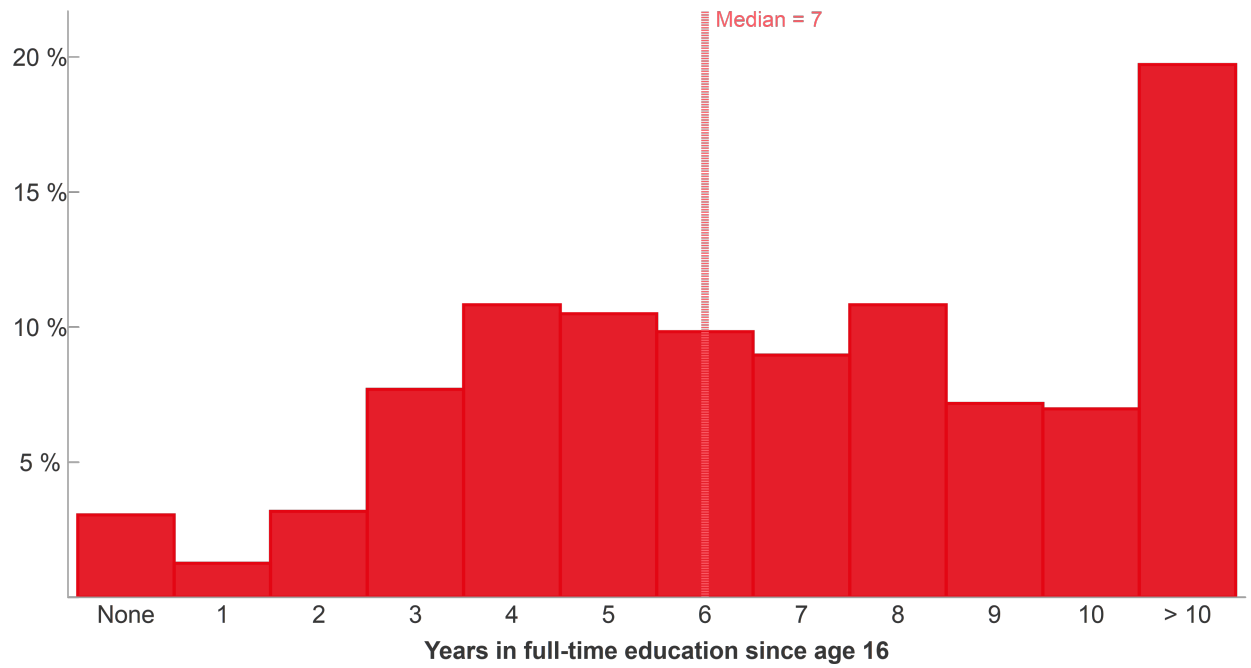
3.5 Education, employment, and financial coping

Study participants were asked, *"How many years have you spent in full-time education since the age of 16?"* The median number of years was 7 (N = 1506, missing n = 3). The majority of the respondents fall between four and 10 years in education after the age of 16 (65.1 %). **Figure 3.3** shows the distribution of years spent in full time education beyond the age of 16. There is an OECD document that provides guidance on how to convert post-16 education into ISCED-1997 degrees at national level [1].

Figure 3.3 Years spent in full time education beyond the age of 16

Figure 3.3: Years spent in full-time education beyond the age of 16 (n = 1506) [Switzerland]

The dashed line indicates the median value.



Study participants were asked, *"Which of the following best describes your current occupation?"* and were offered the responses in **Table 3.6**.

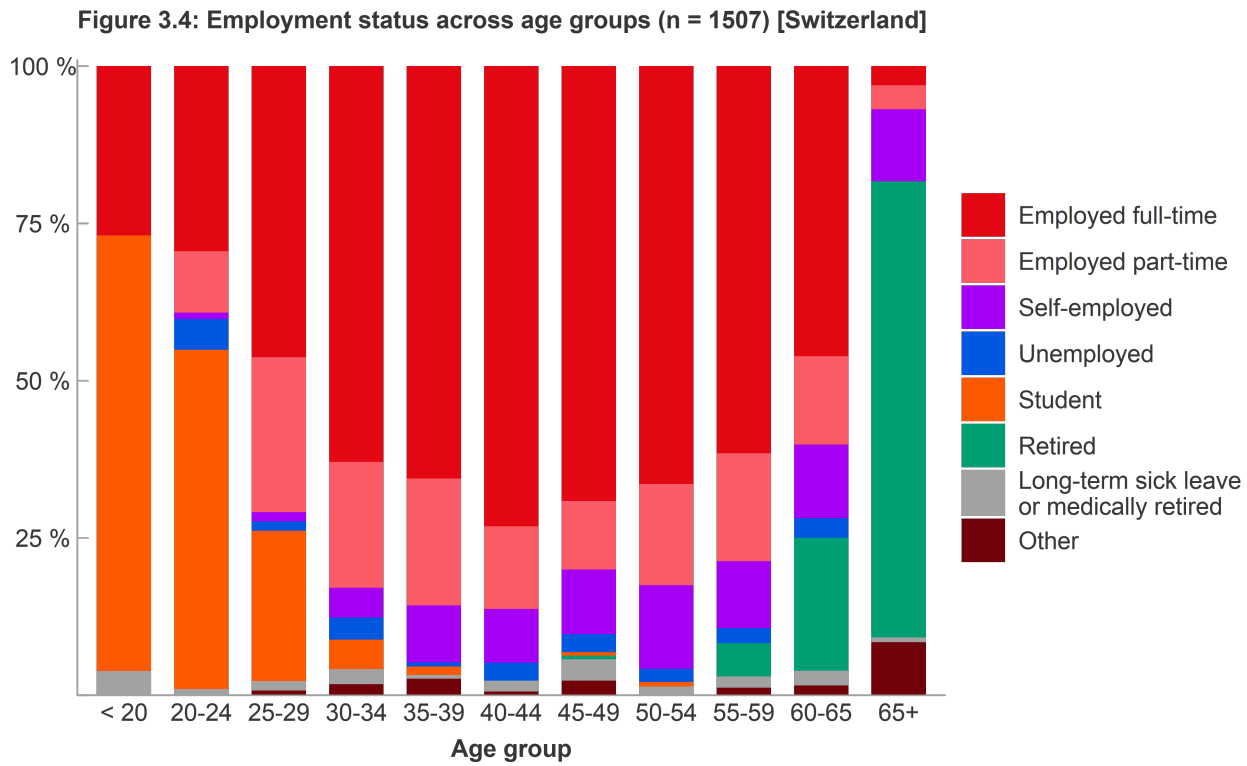
Table 3.6 Current occupation/work status

Current occupation N = 1507	% of all*
Employed full-time	54.3
Employed part-time	14.9
Self-employed	8.3
Unemployed	2.3
Student	7.8
Retired	8.8
Long-term sick leave / medically retired	1.8
Other	1.9
Total	**100**

* Missing n = 2

Around four out of five respondents (77.5 %) are employed. Around one in twelve respondents (8.3 %) are self-employed, and around one in seven (14.9 %) work part-time. The unemployment rate was relatively low at 2.3 %, while students accounted for 7.8 % of the Swiss sample. For a breakdown of unemployment rates by region of residence see **Section 3.9**. The distribution of self-reported employment status across age groups indicates a high level of internal validity.

Figure 3.4 Employment status across age groups



Study participants were also asked, *"Which of these phrases would you say comes closest to your feelings about your income these days?"* and were offered the responses in **Table 3.7**.

Table 3.7 Current occupation/work status

Feelings about income N = 1506	% of all*
Living really comfortably on present income	22.0
Living comfortably on present income	44.6
Neither comfortable nor struggling on present income	23.0
Struggling on present income	8.1
Really struggling on present income	2.3
Total	**100**

* Missing n = 3

Overall, 10.4 % were struggling financially, 23 % were neither struggling nor comfortable on their present income, and 66.5 % were living comfortable on their present income. There was a strong relationship between employment status and financial status, as shown in **Table 3.8**.

Table 3.8 Financial coping by employment status

	Occupation**							
Self-perception of financial status*	Employed full-time, n = 816	Employed part-time n = 225	Self-employed, n = 125	Unemployed, n = 35	Student, n = 117	Retired, n = 132	Long-term sick leave / medically retired, n = 27	Other
Really comfortable	25.9	17.8	28.8	(14.3)	5.1	22.0	(11.1)	0.0
Comfortable	52.1	42.7	33.6	(14.3)	24.8	45.5	(37.0)	0.4
Neither comfortable nor struggling	18.3	28.9	20.8	(28.6)	37.6	25.0	(37.0)	2.9
Struggling	3.6	8.4	12.0	(25.7)	24.8	6.8	(14.8)	8.2
Really struggling	0.2	2.2	4.8	(17.1)	7.7	0.8	(27.0)	11.4

* Missing n = 2; ** Missing n = 3

While overall 10.4 % were struggling financially, 42.9 % of unemployed respondents were struggling, as were 51.9 % of those medically retired or on long-term sick leave (differences from the table may occur due to rounding).

3.6 Sexual attraction, sexual identity, and outness

Study participants were asked, *"Who are you sexually attracted to?"* and were asked to tick as many as apply from: *"Men", "Women", "Non-binary",* and *"I am not attracted to anyone".* **Table 3.9** contains the percentages giving each combination of answers.

Table 3.9 Sexual attraction

Relationships N = 1509	% of all*
Men only	75.0
Women only	0.4
Non-binary people only	0.3
Monosexual	**75.7**
Men and women only	8.3
Men and non-binary only	6.2
Women and non-binary people only	0.3
Bisexual	**14.8**
Men, women and non-binary people	9.1
Polysexual	**9.1**
No one	0.4
Asexual	**0.4**

* Missing n = 0

Overall, 0.4 % of respondents indicated they were not attracted to anyone, 15.9 % were attracted to non-binary people, 18.2 % to women, and 98.6 % to men. All of the respondents who did not indicate they were attracted to men previously had sex with men.

Study participants were asked, *"Which of the following options best describes how you think of yourself?"* and were offered the responses: *"Gay or homosexual", "Bisexual", "Straight or heterosexual", "Any other term",* and *"I don't usually use a term"*. **Table 3.10** shows sexual attraction by sexual identity.

Table 3.10 Sexual attraction by sexual identity

Sexual attraction	Gay or homosexual (%)	Bisexual (%)	Straight or heterosexual (%)	Any other term (%)	Not using a term (%)
Total respondents	**1155**	**223**	**12**	**54**	**62**
Men	92.4	11.2	[25.0]	20.4	35.5
Women	0.1	0.9	[25.0	0.0	0.0
Non-binary	0.0	2.2	[0.0]	0.0	0.0
Men and women	0.8	43.5	[16.7]	9.3	21.0
Men and non-binary people	6.1	1.3	[0.0]	24.1	11.3
Women and non-binary people	0.0	0.4	[16.7]	0.0	1.6
Men, women and non-binary people	0.7	39.5	[16.7]	42.6	27.4
No one	0.0	0.9	[0.0]	3.7	3.2

Overall, 76.7 % of respondents identified as gay or homosexual and 14.8 % as bisexual. Among the remaining respondents, meaningful minorities reported not usually applying any term (4.1 %) or using another term for their sexual identity (0.8 %).

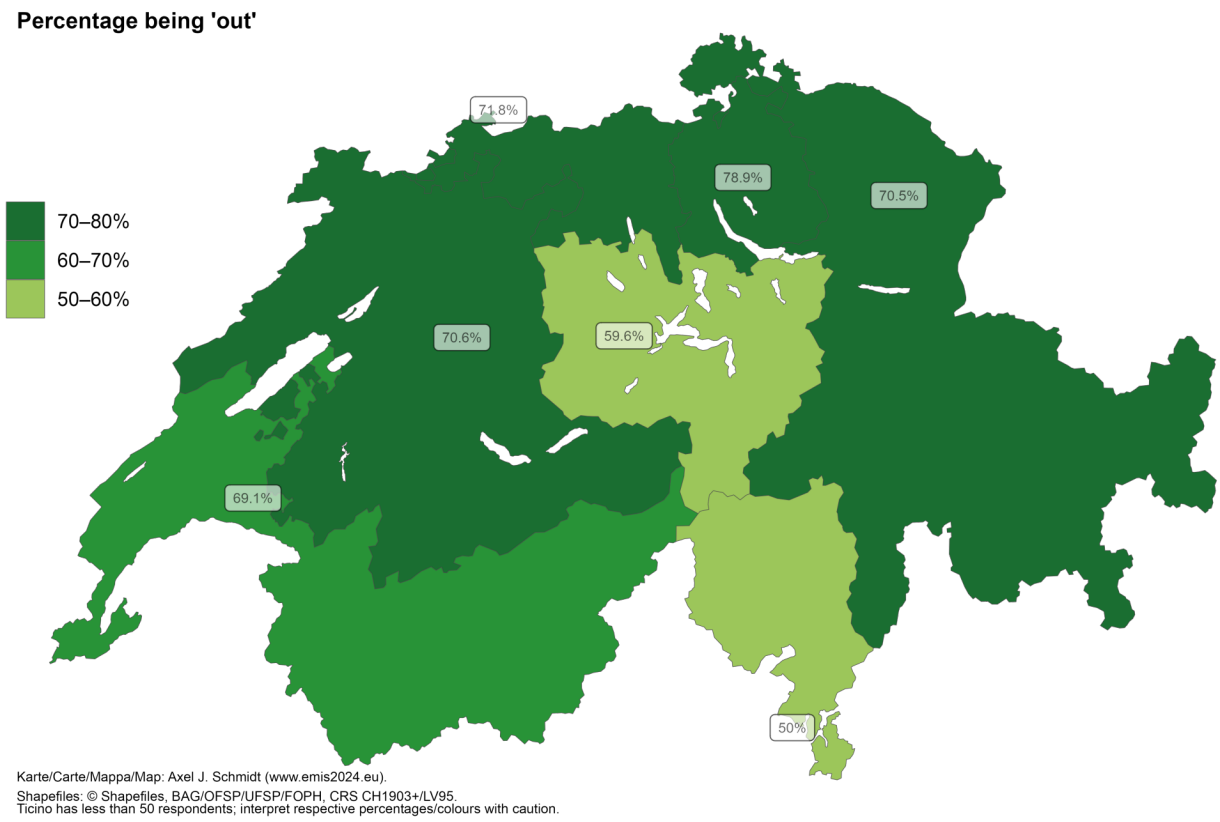
Respondents who were sexually attracted to men (98.6 % of all respondents) were asked: *“Thinking about all the people who know you (including family, friends and work or study colleagues), what proportion know that you are attracted to men?”* They were offered the response options in **Table 3.11**.

Table 3.11 Percentage of people that know respondents are attracted to men (N = 1486)

'Out' to…	%
…all or almost all	55.0
…more than half	16.9
…less than half	7.9
…few	14.3
…none	5.8

A clear majority of respondents (71.9 %) were 'out' to the majority of people they knew about their attraction to men. **Map 3.2** shows considerable variation of outness across Switzerland.

Map 3.2: Percentage being ‘out’ (N = 1486)



'Outness'—the opposite term being 'sexual orientation concealment'—has a major influence on morbidities, behaviour, needs, and access to interventions [2]. **Chapter 9** explores how morbidities, behaviour, needs, and interventions vary to the extent that respondents are open about their sexual attraction to men.

3.7 Current partnerships

Respondents were asked, *“Do you currently have a ‘steady partner’, that is a lover or spouse that means you are not ‘single’?”* and were offered the responses: *"No, I am single"*, *"Yes, I have a steady partner"*, and *"I am not sure/it’s complicated".*

Those who indicated *“Yes, I have a steady partner”* were asked, *“Are you currently in a steady relationship with…?”* and offered the responses: *"One man", "More than one man", "One non-binary person", "More than one non-binary person", "One woman", "More than one woman".*

Table 3.12 shows the percentages giving each response.

Table 3.12 Current partnership and type of steady partner

Current partnership	%	Type of steady partner	%
Single	42.9		
In a relationship with a steady partner	50.9	One man	77.2
		More than one man	2.7
		One woman	15.2
		All other steady relationship	4.8
Complicated	6.2		
Total	**100**		**100**

Around one in two respondents (50.9 %) reported being in a relationship with a steady partner, most commonly one male partner (77.2 %); 42.9 % were currently single, and 12.1 % were uncertain about their relationship status.

Country level differences in the percentage of respondents with a current steady partner are described in **Section 3.9** and differences between single respondents and those with (a) current steady partner/s are described in **Chapter 9**.

3.8 Buying and selling sex

All study participants were asked, *"When was the last time you paid a man to have sex with you? By paid we mean you gave him money, gifts or favours in return for sex"*; and *"When was the last time you were paid by a man to have sex with him? By paid we mean he gave you money, gifts or favours in return for sex".* Each question offered a scale to indicate how recently this had occurred [3].

Table 3.13 Recency of transactional sex

Category	Paid a man for sex	Cumulative %	Was paid by a man for sex	Cumulative %
Within the last 24 hours	0.6	0.6	0.2	0.2
Within the last 7 days	2.0	2.6	0.8	1.0
Within the last 4 weeks	3.0	5.6	0.6	1.6
Within the last 6 months	6.5	12.1	1.3	2.9
Within the last 12 months	3.7	15.8	1.5	4.4
Within the last 5 years	6.8	22.6	2.7	7.1
More than 5 years ago	6.6	29.2	10.7	17.8
Never	70.8	100.0	82.3	100.0
Total	**100**		**100**	

More respondents had bought sex than had sold it, both in their lifetime (29.2 % versus 17.8 %) and in the last 12 months (15.8 % versus 4.4 %).

Respondents who had bought sex in the last 12 months were asked, *"In the last 12 months, how often have you paid a man to have sex with you?"* and respondents who had sold sex in the last 12 months were asked, *"In the last 12 months how often have you been paid by a man to have sex with him?"* For each question they were offered the responses in **Table 3.14**.

Table 3.14 Frequency of transactional sex in the last 12 months

Frequency in the last 12 months	Paid a man to have sex, n = 238	Been paid by a man to have sex with, n = 63
1-2 times	57.1	57.1
3-10 times	34.5	30.2
11-50 times	6.7	11.1
More than 50 times	1.7	1.6
Total	**100**	**100**

The majority of respondents who had either sold or bought sex in the last 12 months had done so only once or twice. For a description of how buying sex from a man and selling sex to men varies by country of residence see **Section 3.9**. **Chapter 9** compares the respondents who sold sex three or more times in the last 12 months with those who did less frequently, longer ago, or not at all.

3.9 Regional variation in demographics

Table 3.15a Regional variation in key demographics

Qualifying cases	Switzerland	% assigned female sex at birth	Age (median)	% living in 100 000+ settlements	% born abroad	% refugee or asylum seeker	% with higher education (>5 years after age 16)
1 509	**Overall Total**	**4.1**	**44**	**39.4**	**28.5**	**0.4**	**63.6**
	Regions						
313	Région lémanique	3.2	40	51.1	32.9	0.6	68.3
266	Espace Mittelland	5.3	46	27.2	21.4	0.4	61
197	Nordwestschweiz	1.5	44	32.7	27.9	0	67.5
486	Zürich	4.9	45	57.9	32.7	0.6	60.9
107	Ostschweiz	5.6	47	5.6	23.4	0	54.2
89	Zentralschweiz	(4.5)	47	(5.6)	(21.3)	(0)	(68.5)
35	Ticino	(0)	45	(2.9)	(20)	(0)	(74.3)
	Cities						
262	Zürich	4.6		100	40.8	0.4	70.2
157	Geneva-Lausanne	2.5	40	100	39.5	0.6	75.2

Numbers in parentheses ( ) indicate that the total number of respondents for that category is less than 100 (N < 100).
Numbers in brackets [ ] indicate that the total number of respondents is less than 20 (N < 20).

Table 3.15b Regional variation in key demographics (continued)

Qualifying cases	Switzerland	% unemployed	% struggling on present income	% identifying as gay or homosexual	% out to few or none of friends, family and at work	% with current steady partner	% bought sex from a man at least once, last 12m	% sold sex to a man 3+ times, last 12m
1 509	**Overall Total**	**4**	**10.5**	**76.8**	**20.1**	**50.9**	**15.8**	**1.7**
	Regions							
313	Région lémanique	4.8	13.5	74.3	23.2	51.4	10.9	1.3
266	Espace Mittelland	4.2	8.3	79.3	21	51.9	16.5	2.3
197	Nordwestschweiz	4.1	9.1	76.6	19.5	50.8	15.2	2.5
486	Zürich	3.9	8.8	80.2	14.3	53.5	17.9	2.1
107	Ostschweiz	1.9	12.1	72	22.9	43.9	18.7	0
89	Zentralschweiz	(4.5)	(11.2)	(74.2)	(27)	(41.6)	(14.6)	(1.1)
35	Ticino	(2.9)	(22.9)	(55.9)	(44.1)	(48.6)	(22.9)	(0)
	Cities							
262	Zürich	5.3	8	86.3	8.5	50.4	16.4	2.3
157	Geneva-Lausanne	6.4	13.5	84.1	12.2	54.1	13.4	1.9

Numbers in parentheses ( ) indicate that the total number of respondents for that category is less than 100 (N < 100).
Numbers in brackets [ ] indicate that the total number of respondents is less than 20 (N < 20).

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1. OECD. Classifying educational programmes. Manual for ISCED-97 implementation in OECD countries. Organisation for Economic Cooperation and Development; 1999 [cited 2025 Sep 5]. Available from: https://stat.gl/publ/kl/UD/199701/periaaseq/Classifying%20Educational%20Programmes%20-%20Manual%20for%20ISCED-97%20Implementation%20in%20OECD%20Countries.pdf

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Chapter 4: Morbidities

Morbidity includes both physical and psychological ill health. For a health programme, prevention of and reduction in prevalence or severity of morbidities are the ultimate outcomes sought. EMIS-2024 asked about two areas of morbidity: mental ill-health and sexually transmitted infections. Due to missing input from a collaborating partner, this chapter is not complete in the report version of 24-10-2025.

This chapter describes all the indicators of morbidity used in EMIS-2024 across the whole sample, and by region/city in the tables at the end of the chapter. **Chapter 8** describes morbidities in the four trans groups recruited in the survey. **Chapter 9** considers how these morbidity indicators vary between specific target groups for sexual health interventions.

4.1 Mental health problems

Poor mental health is a major cause of morbidity and is more common in sexual minorities than in the sexual majority. In addition, the association between poor mental health and HIV transmission risk behaviour (that is, sexual risk behaviour and poor medication adherence) is well established. This is one mechanism by which multiple morbidities occur in the same people, a phenomenon also known as syndemics.

4.1.1 Anxiety/depression (PHQ-4)

We used the Patient Health Questionaire-4, a short clinical screening tool that measures combined anxiety and depression, to give an indication of mental well-being. While the tool is not intended to be diagnostic, and may overestimate the prevalence of problems, it was chosen for its brevity and ease of interpretation. Study participants were asked, *"Over the last 2 weeks, how often have you been bothered by the following problems?"* and were offered the following four responses: Feeling nervous, anxious or on edge; Not being able to stop or control worrying; Little interest or pleasure in doing things; Feeling down, depressed, or hopeless. Responses included not at all (0 points); some days (1 point); more than half the days (2 points); nearly every day (3 points). The total points give a score from 0 to 12 which can be grouped into four bands. **Table 4.1** gives the percentage of respondents falling in each band (missing for 1 %) and the usual interpretation for this validated scale.

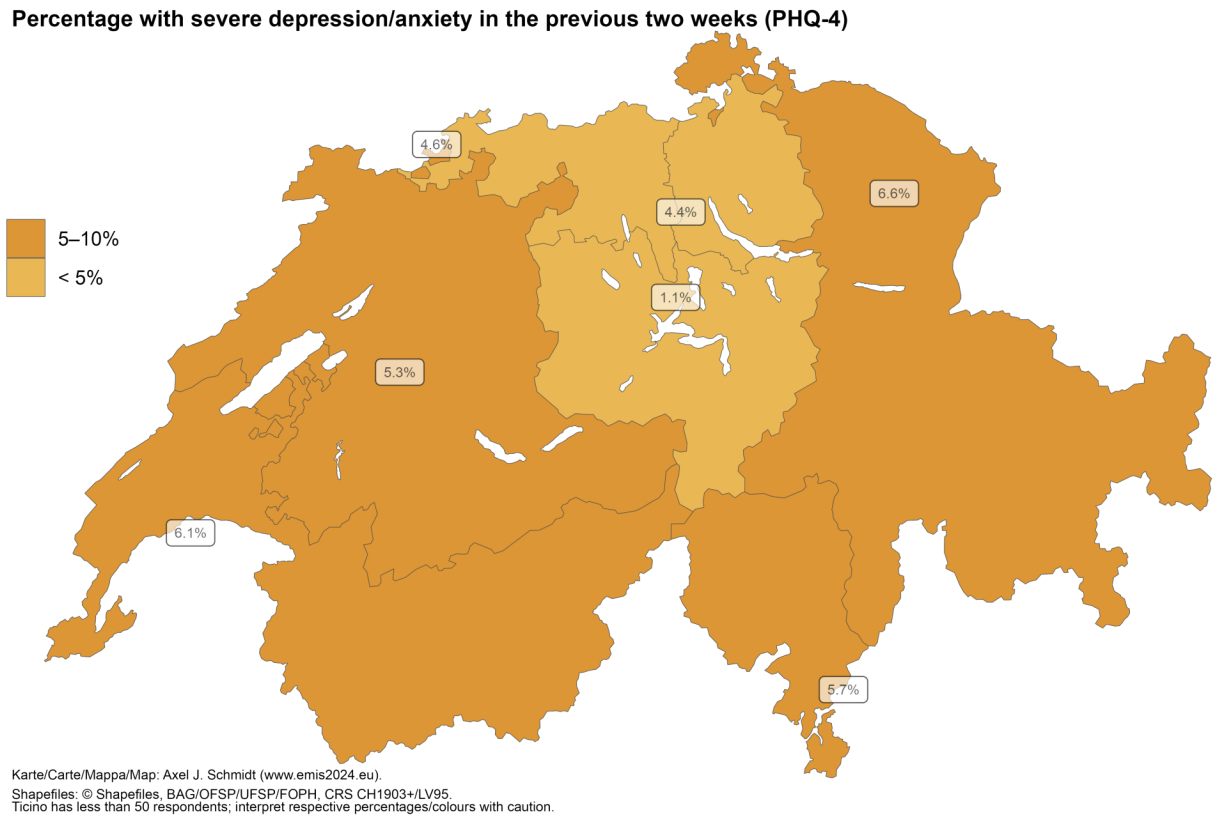
Table 4.1 Anxiety and depression (PHQ-4) score

PHQ-4 score	Interpretation	n*	% of all
0–2	Normal	803	53.7
3–5	Mild anxiety and depression	470	31.5
6–8	Moderate anxiety and depression	147	9.8
9–12	Severe anxiety and depression	74	5.0
Total		**1 494**	**100**

* Missing n = 15

Overall, 14.8 % reported at least moderate anxiety and depression in the last two weeks, with one-in-twenty (5 %) experiencing severe anxiety and depression in the same time period. **Section 4.3** shows region-level figures for the percentage experiencing severe anxiety and depression, and Chapter 9 considers how the percentage experiencing severe anxiety and depression varies between key target groups.

Map 4.1 Percentage with severe anxiety or depression in last two weeks (PHQ-4) (N = sum)



4.1.2 Suicidal ideation

Study participants were asked, *"Over the last 2 weeks, how often have you been bothered by the following problems?"* followed by the statement: *"Thoughts that you would be better off dead, or of hurting yourself in some way"*. In 2024 an additional item of *"Thoughts about taking your own life"* was added. The table gives the response options and the percentage of respondents indicating each option.

Table 4.2 Suicidal ideation over the last two weeks

	Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead, or of hurting yourself in some way? N = 1497	Over the last 2 weeks, how often have you been bothered by thoughts about taking your own life? N = 1498
Not at all	84.1	89.5
Some days	12.5	8.9
More than half the days	1.8	1.1
Nearly every day	1.6	0.5
Total	**100**	**100**

* Missing n = 12; ** Missing n = 11

Overall, 15.9 % had thought of harming themselves in the past two weeks and 3.4 % had thought of harming themselves on at least half of the days during that period. The proportion of those who had thought about taking their own life in the past two weeks 10.5 %, and 1.6 % had thought of taking their own life on at least half of the days.

Section 4.3 shows region-level figures for the percentage having had thoughts of harming themselves and taking their own life in the past two weeks. **Chapter 9** considers how the percentage having had thoughts of harming themselves or taking their own life varies across key target groups.

Morbidities are associated with each other

The frequency of suicidal ideation was strongly associated with reported levels of anxiety and depression. The proportion of respondents who thought nearly every day about harming themselves was 0 % of those with a normal anxiety and depression score, 0.2 % of those with a mild anxiety and depression score, 2.1 %

of those with a moderate anxiety and depression score and 27 % of those with a severe anxiety and depression score.

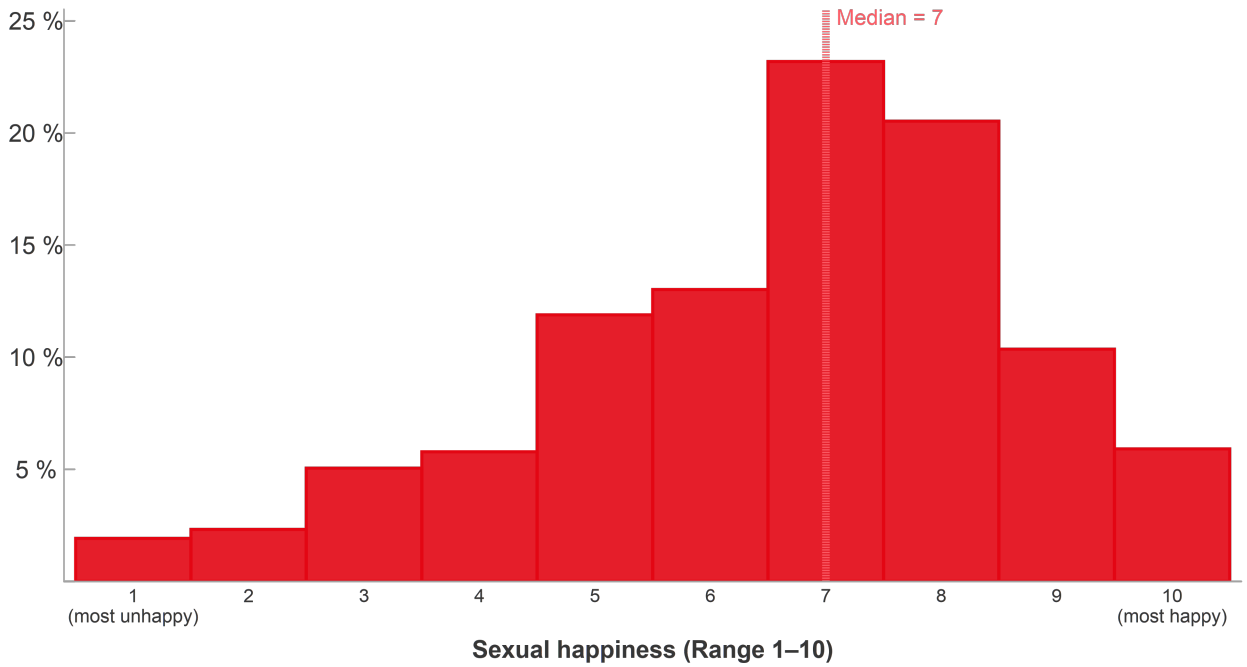
4.1.3 Sexual unhappiness

Study 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?"* and were offered a ten-point scale labelled at the ends (1, most unhappy; 10, most happy). **Figure 4.1** shows the profile of all scores. **Section 4.3** shows region-level figures for the percentage reporting a sexual happiness score of 1–4, and **Chapter 9** considers how this percentage varies across key target groups.

Figure 4.1 Sexual happiness self-rating on a scale of 1 to 10, where 1 is the most unhappy and 10 is the most happy

Figure 4.1: Sexual happiness (n = 1505)

The dashed line indicates the median value.



Morbidities are associated with each other

On average, a lower sexual happiness score was given by respondents with higher levels of anxiety and depression. The mean sexual happiness score for respondents with a normal anxiety and depression score was 7.0; for those with mild anxiety and depression it was 6.4; for those with moderate anxiety and depression it was 5.6; and for those with severe anxiety and depression it was 5.3. Similarly, the more frequently respondents thought about suicide or self-harm, the lower was their sexual happiness score.

4.1.4 Alcohol dependency (CAGE4)

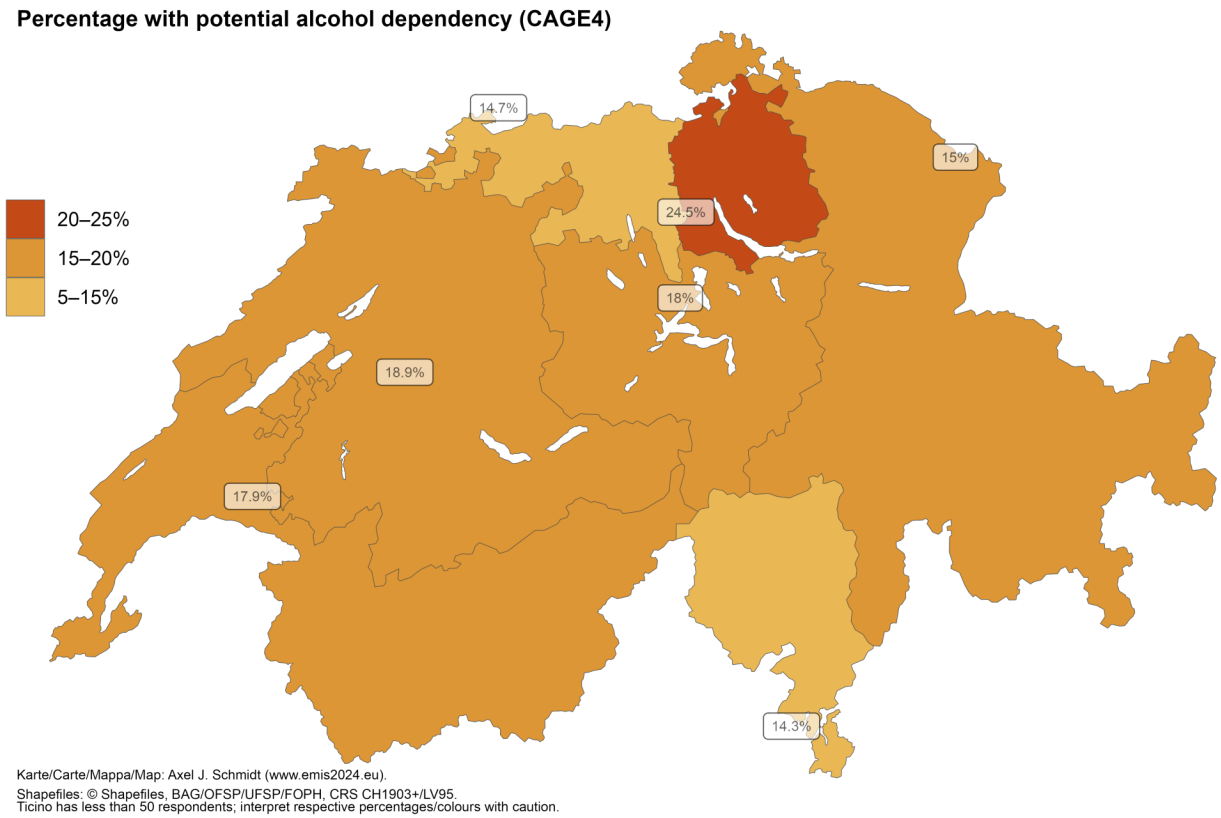
We used the CAGE4 screening tool for alcohol dependency. While the tool is not intended to be diagnostic and may over-estimate the prevalence of problems, it was chosen for its brevity and ease of interpretation.

Study participants were asked, *"Thinking about drinking alcohol in the past 12 months…",* followed by four questions to which they could respond "*Yes*": or *"No":*

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

Indicating “Yes” to two or more statements is a positive response, indicating possible alcohol dependency. Overall, 19.5 % (N = 1507) met the criteria for potential alcohol dependency. **Section 4.3** shows region-level figures for likely alcohol dependence and **Chapter 9** considers how this percentage varies between key target groups.

Map 4.2 Percentage with potential alcohol dependency (CAGE4) (N = sum)



Morbidities are associated with each other

Potential alcohol dependency was more common in respondents with greater levels of anxiety and depression: 27% % in those with a severe anxiety and depression score; and 14.6 % in those with a normal anxiety and depression score.

Similarly, alcohol dependency was more common in respondents with more frequent suicidal ideation: 25 % among those who thought about it nearly every day vs. 17.3 % of those who had not thought about harming themselves in the last two weeks.

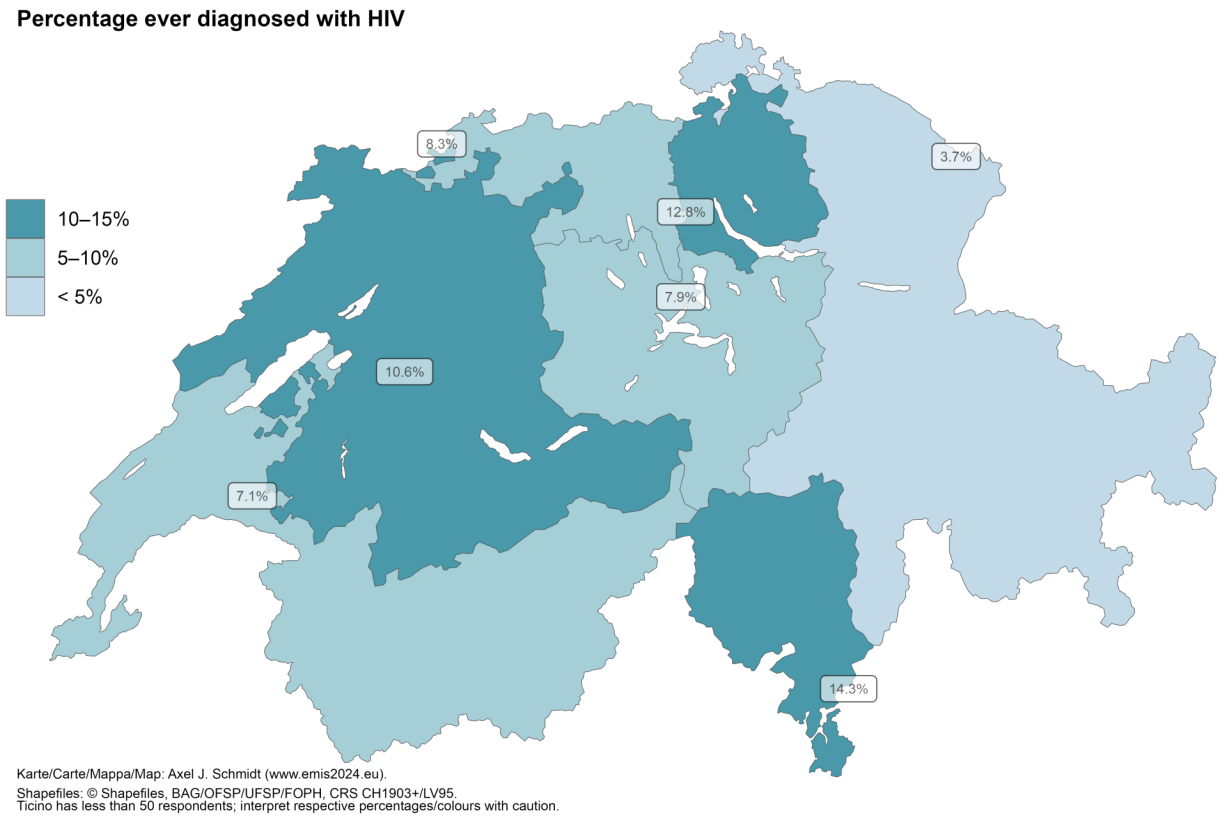
4.2 Diagnoses of HIV and sexually transmitted infections

Sexually transmitted infections are a common sexual health morbidity among MSM and a key concern driving EMIS-2024. Since all measures in the survey were self-reported, diagnoses of infections were used as a proxy for their acquisition.

4.2.1 Prevalence and incidence of HIV diagnoses

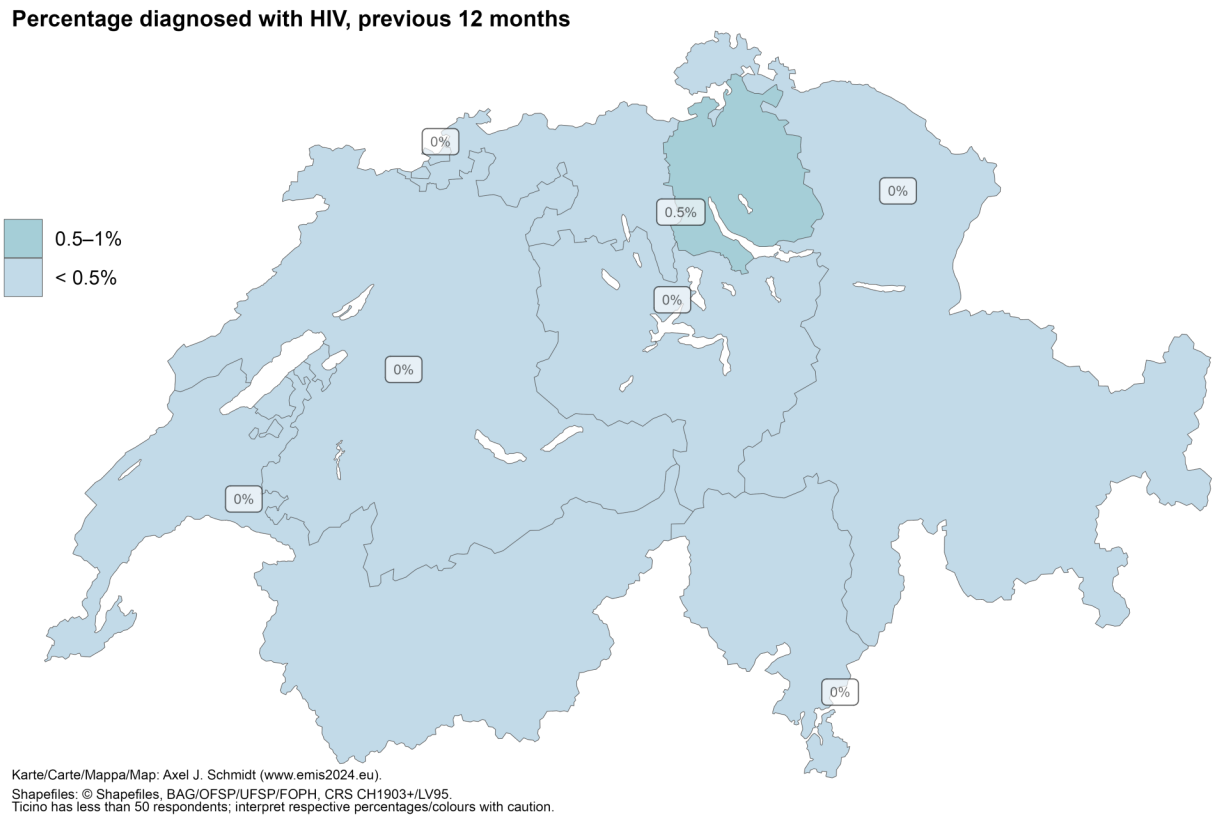
Study participants were asked, "*Have you ever been diagnosed with HIV?"* Just over one-in-ten (9.8 %, N=1497, missing n= 12) indicated *"Yes".* **Section 4.3** shows region-level figures for self-reporting diagnosed HIV. **Chapter 9** compares the minority group of respondents living with diagnosed HIV against the majority of respondents without diagnosed HIV.

Map 4.3 Percentage ever diagnosed with HIV



Study participants with diagnosed HIV were asked whether they were diagnosed with HIV in the past 12 months. Excluding those who had already been diagnosed 12 months ago, the percentage of all respondents who received an initial HIV diagnosis in the last 12 months was 0.1 % (n = 2). **Section 4.3** shows figures for the overall percentage diagnosed with HIV in the last 12 months for all countries.

Map 4.4 Percentage diagnosed with HIV, last 12 months



4.2.2 Unsuppressed diagnosed HIV

Study participants who self-reported that they had ever received an HIV diagnosis (9.8 % of all) were asked: *"What was the result of your viral load test the last time you had your HIV infection monitored?"* **Table 4.3** shows the responses offered and the percentages indicating each response.

Table 4.3 Last HIV viral load test result among respondents that had ever had their HIV infection monitored

Last monitored HIV viral load	% of all respondents N = 146
Undetectable	98.6
Detectable	0.7
I was told but I don't remember the result	-
It was measured but I was not told the result	0.7
It was not measured	-
I don't remember	-
I don't understand the question	-
[Never medically monitored]	0.0
Total	**100**

4.2.3 Most recent diagnoses of syphilis, gonorrhoea and chlamydia

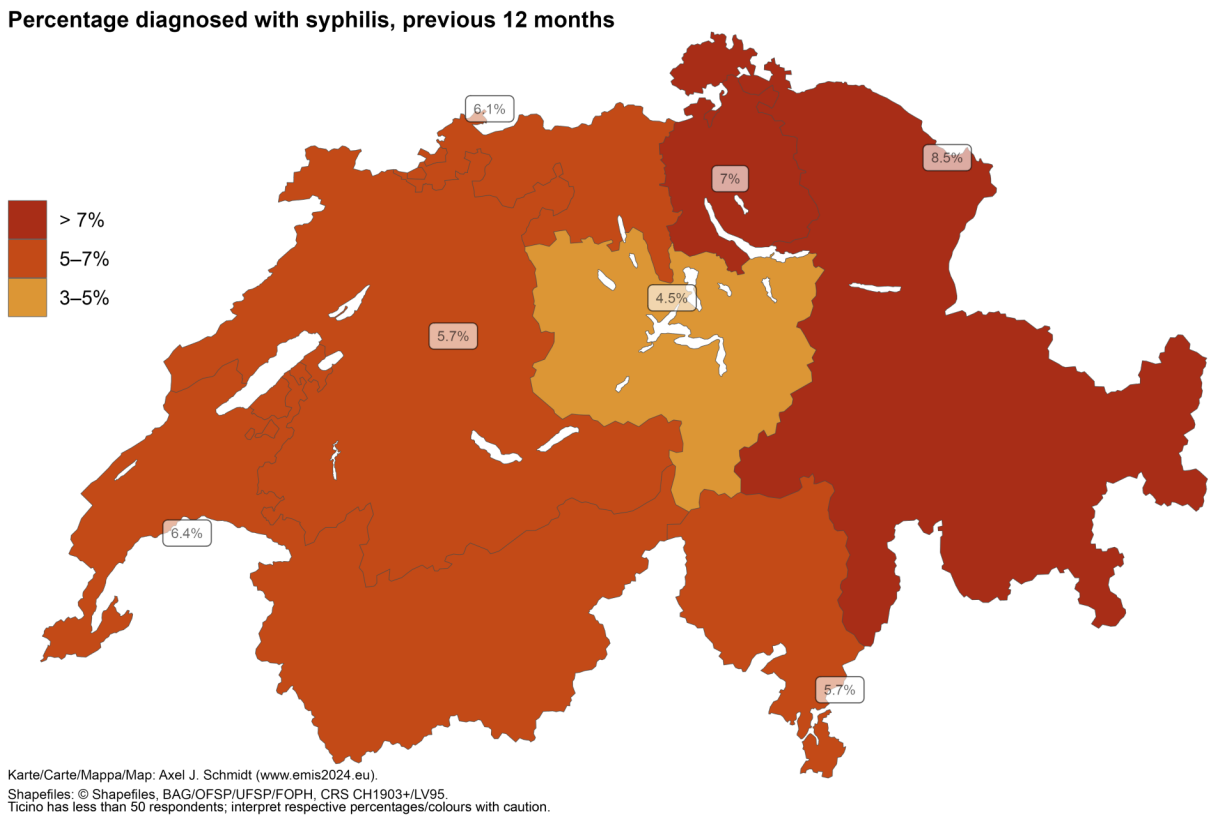
All study participants were asked: *"Have you ever been diagnosed with syphilis?"* Respondents who answered yes, were asked, *"When were you last diagnosed with syphilis?"* and offered a scale to indicate how recently this had been. Identical questions were asked for "*gonorrhoea"* and *"chlamydia or LGV"*. The table shows how recently the diagnosis had occurred for respondents who had reported ever having been diagnosed with these three sexually transmitted infections.

Table 4.4 Recency of diagnosis with syphilis, gonorrhoea, chlamydia or LGV

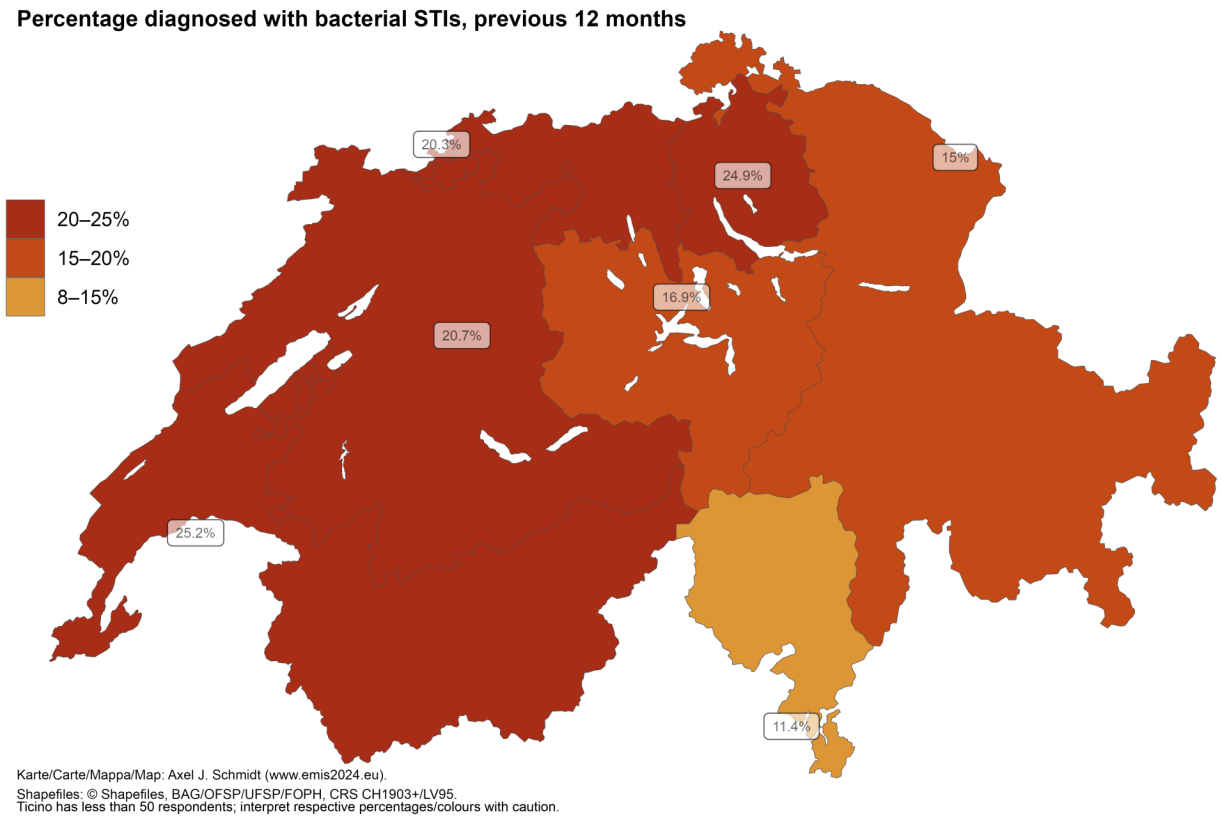
Diagnosis recency of...	Syphilis* N = 1506		Gonorrhoea** N = 1509		Chlamydia/LGV*** N = 1509	
	%	Cumulative %	%	Cumulative %	%	Cumulative %
Within the last 24 hours	0.1	0.1	-	-	-	-
Within the last 7 days	0.1	0.2	0.3	0.3	0.2	0.2
Within the last 4 weeks	0.4	0.6	1.1	1.4	1.0	1.2
Within the last 6 months	2.1	2.7	4.7	6.1	4.9	6.1
Within the last 12 months	3.6	6.3	7.3	13.4	6.4	12.5
Within the last 5 years	9.0	15.3	12.8	26.2	13.5	26.0
More than 5 years ago	8.6	23.9	10.6	36.8	6.3	32.3
Never	76.0	100.0	63.2	100.0	67.7	100.0
Total	**100**		**100**		**100**	

* Missing n = 3; ** Missing n = 0; *** Missing n = 0

Map 4.5 Percentage diagnosed with syphilis, previous 12 months



Map 4.6 Percentage diagnosed with bacterial STIs, previous 12 months



To distinguish between gonorrhoea and chlamydia that had been diagnosed by screening asymptomatic people and gonorrhoea and chlamydia that had been diagnosed due to symptoms a new question had been included *"The last time you were diagnosed with gonorrhoea/chlamydia, what was the reason for testing?"*

The response options were:

- *I had symptoms (pain, discharge etc)*
- *I checked for STIs without having symptoms*
- *I was notified by a partner who had gonorrhoea*
- *None of the above*

The proportion of respondents with gonorrhoea diagnosis who reported symptoms as the reason for testing was 37.4 %, the proportion with symptomatic chlamydia was 27.5 %. The distribution of testing reasons is shown in **Table 4.5**.

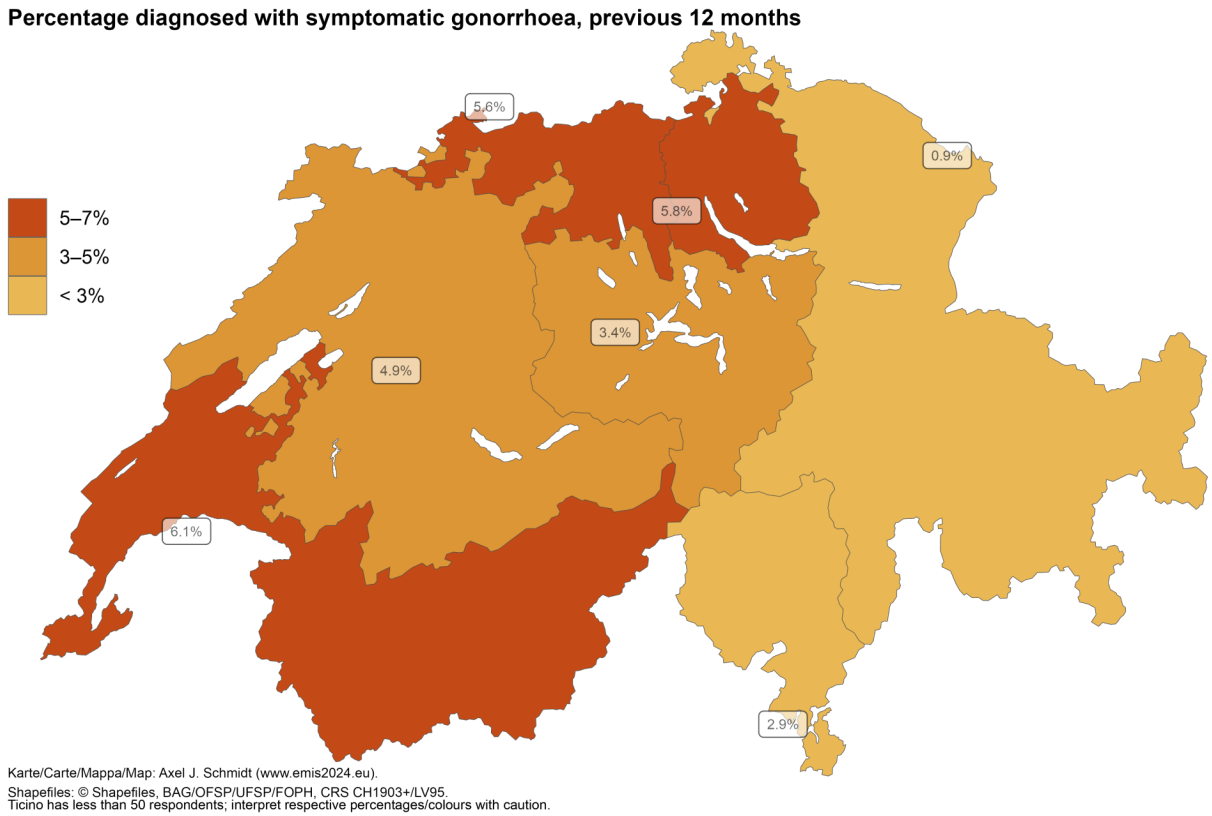
Table 4.5 Testing reasons for gonorrhoea and chlamydia

Testing reason	for gonorrhoea* N = 203	for chlamydia** N = 189
	% of all	% of all
I had symptoms (pain, discharge etc)	37.4	27.5
I checked for STIs without having symptoms	43.3	59.3
I was notified by a partner who had gonorrhoea/chlamydia	15.8	12.7
None of the above	3.4	0.5
Total	**100**	**100**

* Missing n = 0; ** Missing n = 0

Gonorrhoea was the bacterial STI most commonly diagnosed in the last 12 months or ever, but all three infections followed a similar pattern. **Section 4.3** shows region-level data for self-reporting of the three infections in the last 12 months, and **Chapter 9** considers how they vary across key target groups.

Map 4.7 Percentage diagnosed with symptomatic gonorrhoea, previous 12 months



4.2.4 First diagnosis of anal or genital warts (HPV infection)

Anal or genital warts are the most common STI but often remain undiagnosed or even unnoticed, especially when they manifest around, or even within the anus. A safe and expensive vaccine is available, but in most European healthcare systems it is only recommended/reimbursed for girls and young women and not for boys and men. As most MSM do not profit from herd immunity (as heterosexual young men do when most of their female sex partners are vaccinated), human papilloma virus (HPV) infections remain a problem for MSM. Unlike syphilis and chlamydia, anal or genital warts are difficult to treat and tend be become chronic. For this reason, we asked for the first and not the last diagnosis of warts.

All study participants were asked, *"Have you ever been diagnosed with anal or genital warts?"* Study participants who responded positively were asked, *"When were you first diagnosed with anal or genital warts?"* and offered a scale to indicate how recently they had been diagnosed. The table shows how recently the first diagnoses were made among respondents that had ever had the infection.

Table 4.6 Recency of first diagnosis with anal or genital warts

Last time diagnosed with anal or genital warts	All respondents* N = 1508	
	%	Cumulative %
Within the last 24 hours	0.0	0.0
Within the last 7 days	0.1	0.1
Within the last 4 weeks	0.1	0.2
Within the last 6 months	0.7	0.9
Within the last 12 months	0.5	1.4
Within the last 5 years	4.5	5.9
More than 5 years ago	11.6	17.5
Never	82.4	99.9
Total	**100**	

* Missing n = 1

Around one in six respondents (17.7 %) reported ever having been diagnosed with anal or genital warts. **Section 4.3** shows region-level data for self-reporting of having ever been diagnosed with anal or genital warts. **Chapter 9** considers how the infection varies across key target groups.

4.2.5 Diagnosis of mpox

In April 2022 an outbreak of mpox was detected in Europe, which primarily affected men who had sex with men. In the following months this outbreak spread to more than 100 countries all over the world. An attenuated pox vaccine (MVA) was approved for vaccination against mpox, but vaccine supplies were not sufficient and many countries experienced shortage of vaccine supplies. All study participants were asked, "*Have you had mpox (monkeypox) since 2022?"* Response options and how often they were selected is shown in **Table 4.7**.

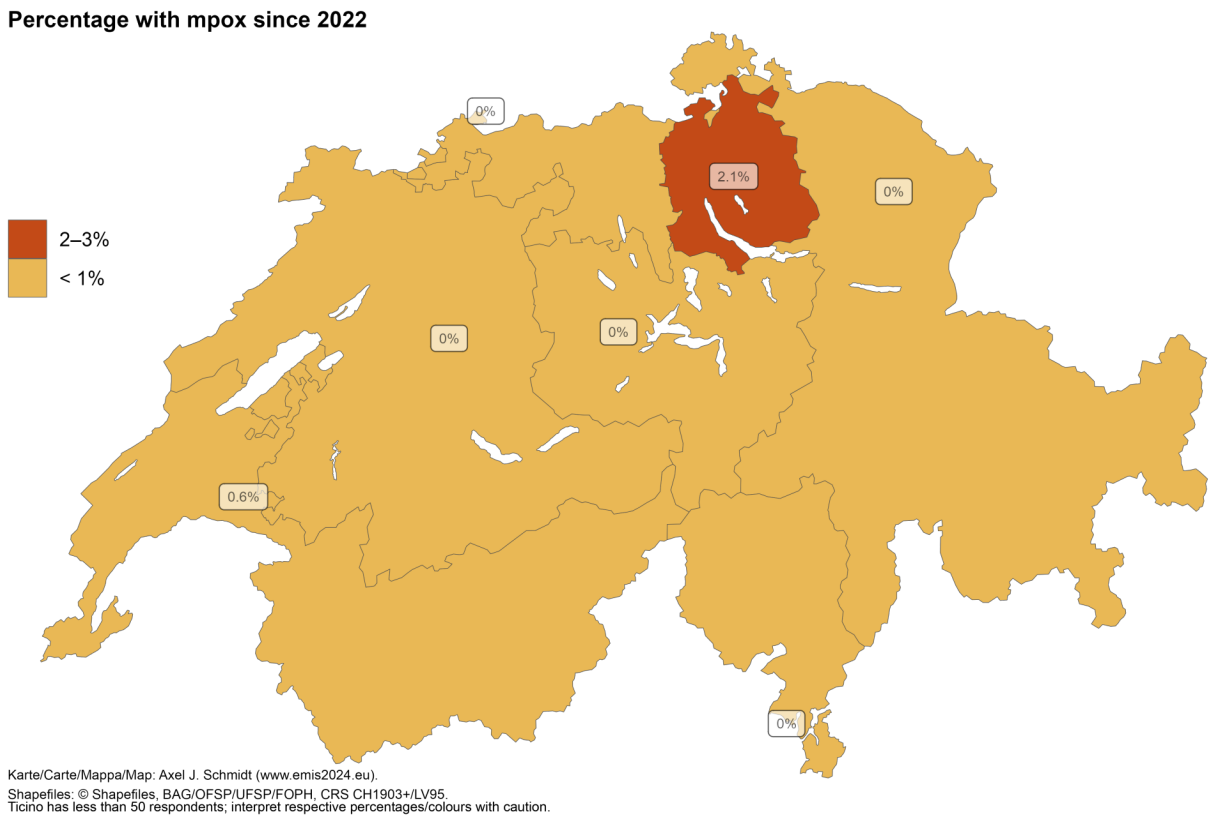
Since not all mpox infections cause characteristic symptoms and not all people with symptoms were clinically tested and diagnosed, the proportion of 0.8 % of survey participants who received an mpox diagnosis is a lower limit for the mpox infections that occurred among the survey participants. **Section 4.3** shows region-level data for self-reporting of having ever been diagnosed with mpox.

Table 4.7 Mpox diagnosis

Mpox diagnosis N = 1508	All respondents*
	%
No, and I had no symptoms suggestive of mpox infection	97.7
No, but I had symptoms which might have been caused by mpox	0.9
Yes, and I was diagnosed by a doctor	0.7
Yes, but I was not diagnosed in a health care setting	0.1
I don't know	0.6
Total	**100**

* Missing n = 1

Map 4.8 Percentage with Mpox since 2022



4.2.6 Viral hepatitis

Study participants were asked about their vaccination status regarding hepatitis A and B. The answer options included *"No, because I've had hepatitis A (and am now naturally immune)"*, or "*No, because I've had hepatitis B (and am now naturally immune)"*, respectively. As hepatitis B can become chronic, an additional answer was offered: *"No, I have chronic hepatitis B infection"*. Of all respondents, 3.9 % reported past hepatitis A, and 3.0 % reported past hepatitis B infection that had cleared. No respondent in Switzerland reported chronic hepatitis B.

Study participants were asked, *"Have you ever been diagnosed with hepatitis C?"* and were offered the responses: No; Yes; I don't know. Overall, 1.5 % indicated *"Yes"* (and 1.7 % indicated *"don't know"*). Respondents with self-reported hepatitis C diagnoses were asked, "*When were you first diagnosed with hepatitis C?"* and were offered a scale to indicate how recently the diagnosis had been made (see **Table 4.8**).

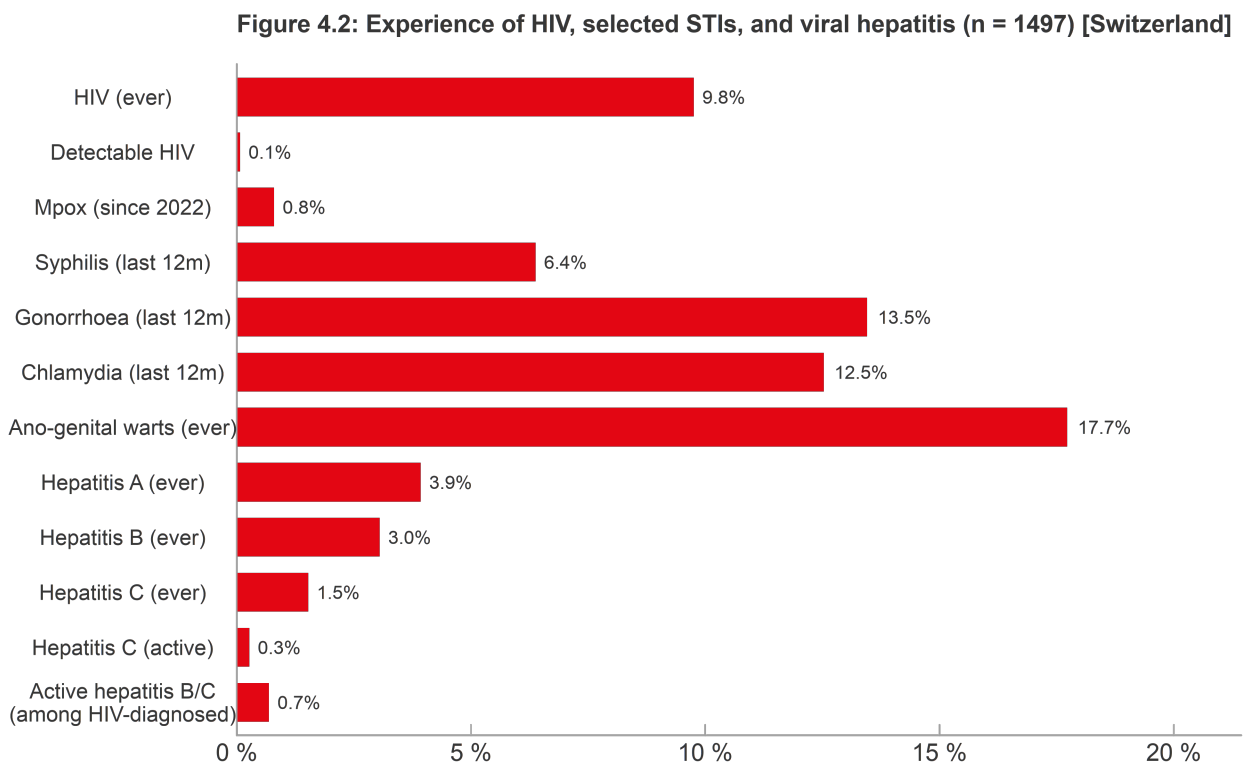
Table 4.8 Recency of first diagnosis with hepatitis C

Last time diagnosed with Hepatitis C N = 1509	All respondents*	
	%	Cumulative %
Within the last 24 hours	0.0	0.0
Within the last 7 days	0.0	0.0
Within the last 4 weeks	0.0	0.0
Within the last 6 months	0.1	0.1
Within the last 12 months	0.1	0.2
Within the last 5 years	0.3	0.5
More than 5 years ago	1.1	1.6
Never	98.5	100.0
Total	**100**	

* Missing n = 0

Among the 23 respondents who had ever been diagnosed with hepatitis C, three (13 %) were first diagnosed in the past 12 months. Respondents who had ever been diagnosed with hepatitis C were asked, *"How many times have you picked up hepatitis C infection?"* and were offered the options: Once; Twice; Three times or more. Of the respondents who had been diagnosed with hepatitis C, three had had it twice—all of them living with diagnosed HIV. Most respondents with a history of hepatitis C said that it cleared—either spontaneously without treatment (n = 5) or with treatment (n = 13). However, four respondents who had ever been diagnosed with hepatitis C said that they still had it.

Figure 4.2 Experience of HIV, selected STIs, and viral hepatitis



4.3 Regional variation in morbidities

Table 4.9a Regional variation in key morbidities

Qualifying cases	Switzerland	% with severe anxiety and depression	% with self-harm thoughts	% with suicidal thought	% sexually unhappy	% with potential alcohol dependency
1 509	**Overall Total**	**4.9**	**3.4**	**1.6**	**15**	**19.5**
	Regions					
313	Région lémanique	6.1	3.5	1.3	18.5	17.9
266	Espace Mittelland	5.3	3.4	1.9	15	18.9
197	Nordwestschweiz	4.6	3.1	1	11.7	14.7
486	Zürich	4.4	2.7	1	12.2	24.5
107	Ostschweiz	6.6	3.7	2.8	15.9	15
89	Zentralschweiz	(1.1)	(3.4)	(2.2)	(20.2)	(18)
35	Ticino	(5.7)	(11.8)	(5.9)	(22.9)	(14.3)
	Cities					
262	Zürich	3.5	1.9	0.8	11.1	24.8
157	Geneva-Lausanne	7.1	3.2	1.9	14	17.8

Numbers in parentheses ( ) indicate that the total number of respondents for that category is less than 100 (N < 100).
Numbers in brackets [ ] indicate that the total number of respondents is less than 20 (N < 20).

Table 4.9b Regional variation in key morbidities (continued)

Qualifying cases	Switzerland	% diagnosed with HIV, ever	% diagnosed with HIV, last 12m	% with detectable viral load
1 509	**Overall Total**	**9.7**	**0.1**	**0.7**
	Regions			
313	Région lémanique	7.1	0	(0)
266	Espace Mittelland	10.6	0	(0)
197	Nordwestschweiz	8.3	0	[0]
486	Zürich	12.8	0.5	(1.6)
107	Ostschweiz	3.7	0	[0]
89	Zentralschweiz	(7.9)	(0)	[0]
35	Ticino	(14.3)	(0)	[0]
	Cities			
262	Zürich	14.6	0	(0)
157	Geneva-Lausanne	9.7	0	[0]

Numbers in parentheses ( ) indicate that the total number of respondents for that category is less than 100 (N < 100).
Numbers in brackets [ ] indicate that the total number of respondents is less than 20 (N < 20).

Table 4.9c Regional variation in key morbidities (continued)

Qualifying cases	Switzerland	% diagnosed with syphilis *	% diagnosed with gonorrhoea *	% diagnosed with chlamydia *	% diagnosed with anal/genital warts **	% diagnosed with mpox ***
1 509	**Overall Total**	**6.4**	**13.6**	**12.6**	**17.8**	**0.8**
	Regions					
313	Région lémanique	6.4	18.2	16	17	0.6
266	Espace Mittelland	5.7	12.4	10.2	20.1	0
197	Nordwestschweiz	6.1	11.7	9.6	16	0
486	Zürich	7	15.2	15.4	18.2	2.1
107	Ostschweiz	8.5	5.6	4.7	15	0
89	Zentralschweiz	(4.5)	(7.9)	(12.4)	(16.9)	(0)
35	Ticino	(5.7)	(8.6)	(2.9)	(22.9)	(0)
	Cities					
262	Zürich	7.6	20.6	20.2	21.2	2.7
157	Geneva-Lausanne	6.4	22.3	17.8	23.6	0

Chapter 5: Risk and precaution behaviour

This chapter reports on all activities actually undertaken by the respondents. EMIS-2024 was mainly interested in the behaviour that contributes to or detracts from the morbidities described in **Chapter 4**—risk and precaution behaviour. Due to missing input from a collaborating partner, this chapter is not complete in the report version of 24-10-2025.

We asked about two types of risk behaviour (having sex, taking drugs and doing them together) and four types of precaution behaviour (taking anti-retroviral drugs, sharing HIV status information, using condoms, and being vaccinated). The vaccination questions are not covered in this chapter but will be covered in **Chapter 7**—interventions.

5.1 Taking HIV treatment among respondents with HIV

Overall, 9.8 % (n = 131) indicated they had been diagnosed with HIV (see **Section 4.2.1**). For people diagnosed with HIV, taking anti-retroviral treatment (ART) can result in undetectable levels of viral load which equates to a non-infectious state. Taking HIV treatment is therefore a type of precautionary behaviour to prevent HIV-transmission for respondents with HIV.

5.1.1 Prevalence of HIV antiretroviral treatment taking

Respondents who had ever been diagnosed with HIV were asked, *"Have you ever taken antiretroviral treatment (sometimes known as ART or HAART) for your HIV infection?"* and respondents who had ever taken ART were asked, *"Are you currently taking antiretroviral treatment?"* The percentages giving each response are set out in **Table 5.1**.

Table 5.1 Taking ART among respondents with diagnosed HIV

Taken ART among participants with diagnosed HIV					
Ever	**N***	**%**	**Currently**	**N****	**%**
I don't remember	3	2.1	Currently not taking	0	0
No	12	8.2	Currently taking	131	100
Yes	131	89.7			
Total	**146**	**100**		**131**	**100**

* Missing n = 1; ** Missing n = 0

5.2 Seeking and taking HIV chemoprophylaxis (PEP and PrEP)

Respondents without HIV can reduce their risk of being infected by taking HIV chemoprophylaxis. Taken correctly, PEP (Post-Exposure Prophylaxis) and PrEP (Pre-Exposure Prophylaxis) are very effective means of protection from HIV infection when exposure occurs. Seeking them and taking them are types of precautionary behaviour.

5.2.1 Seeking and taking PEP

Respondents who had never taken an HIV test and those whose last test was HIV negative were asked *"Have you ever taken PEP?"*

Table 5.3 Taking PEP, among all respondents not diagnosed with HIV

Taking PEP N = 1350	Respondents who were not diagnosed with HIV* %
I don't know	0.4
No, I could not get it	4.1
No, I had the opportunity but decided not to take it	3.4
No, I never felt the need to take it	76.4
Yes, I've taken more than one course of pills	6.7
Yes, I've taken one course of pills	9.0
Total	**100**

* Missing n = 1

5.2.2 Seeking and taking PrEP

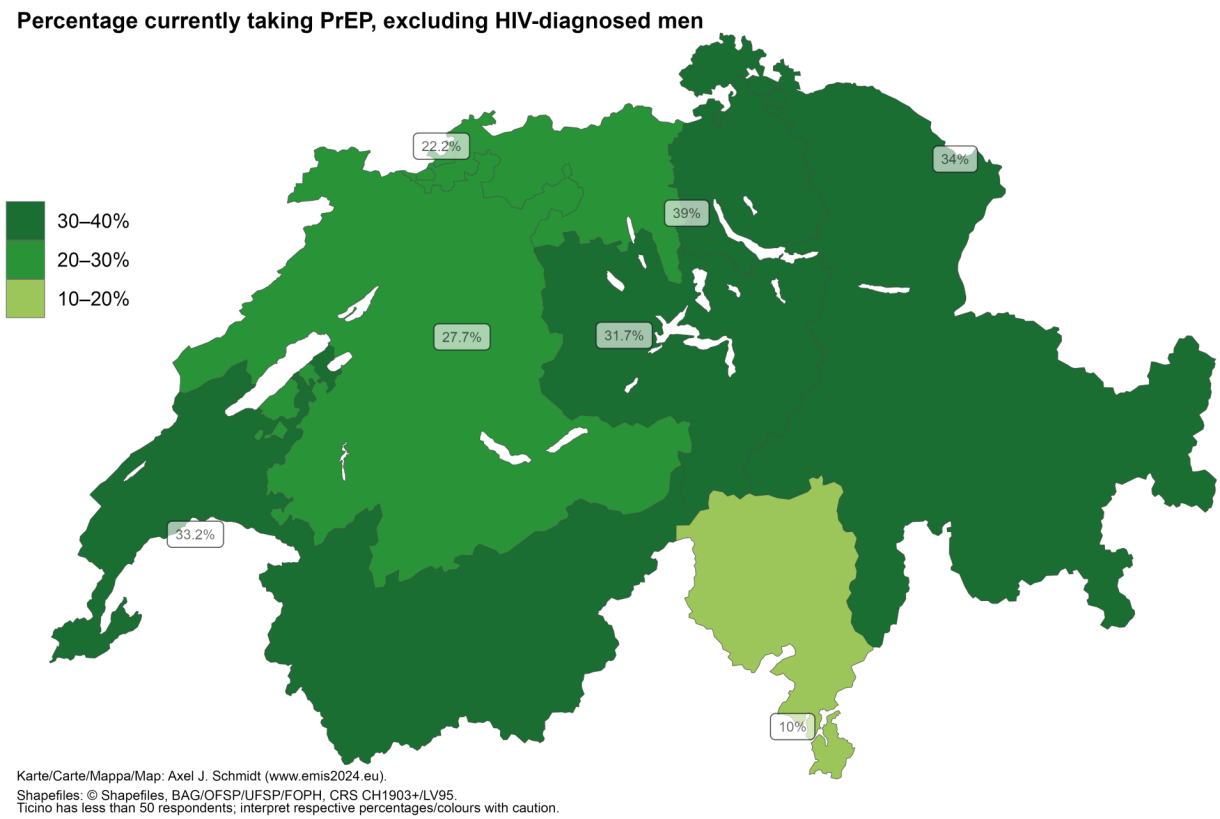
All respondents who had not been diagnosed with HIV were asked, *"Have you ever tried to get PrEP?"* Overall, 39.4 % (N = 1346) indicated they had ever tried to get PrEP. These respondents were also asked, *"Have you ever taken PrEP?"* and were offered the responses in **Table 5.4**.

Table 5.4 Respondents not diagnosed with HIV having ever taken PrEP, by diagnosed HIV status

Ever taken PrEP N = 1346	% not diagnosed with HIV*
No	64.5
Yes, on a daily basis and I'm still taking it	15.8
Yes, on a daily basis but I'm no longer taking it	3.6
Yes, when I have needed it but not daily	16.2
I don't know	
Total	**100**

* Missing n = 5

Map 5.1 Percentage currently taking PrEP, excluding HIV-diagnosed individuals (N = 1346)



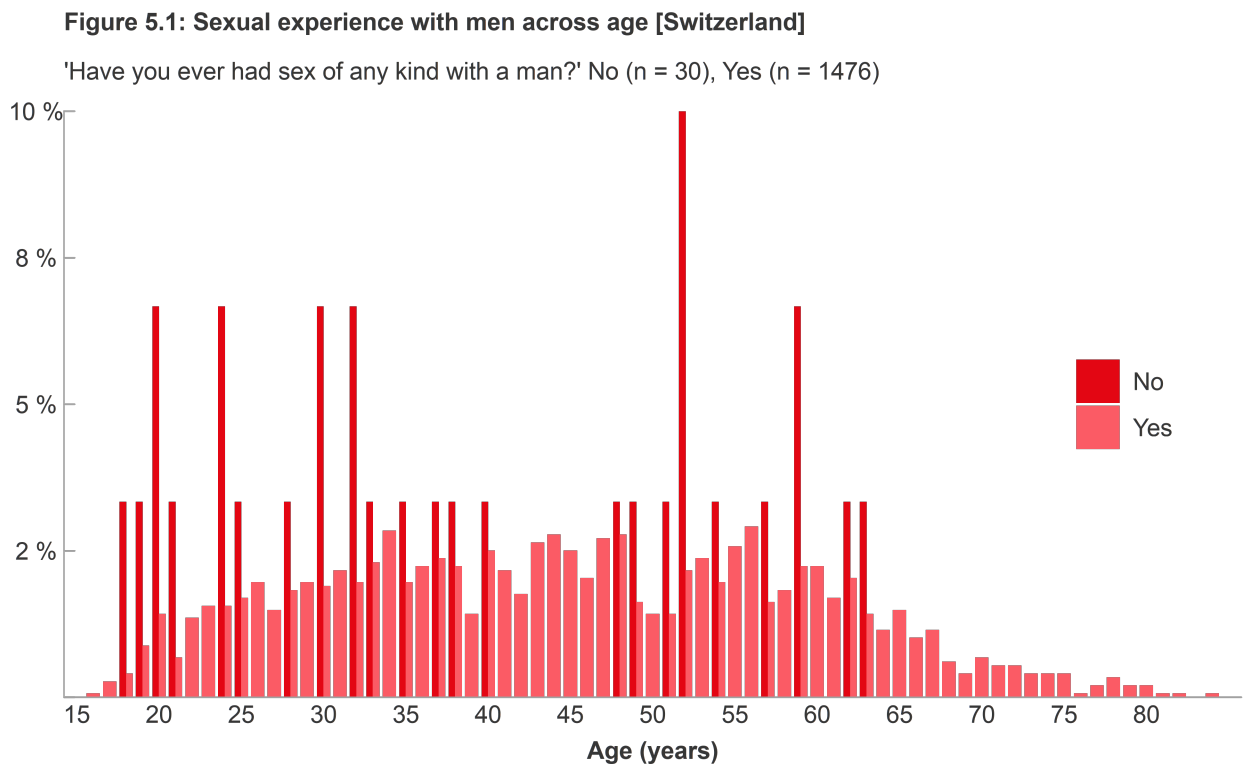
5.3 Having sex

The following **Chapters 5.3–5.6** report about the sexual experiences and male sex partners of the survey respondents. While most, but not all survey respondents were cis MSM, some were trans women, and some were non-binary people assigned female at birth. Thus, the reported sex are mostly homosexual sex acts, and anal intercourse, but also a small proportion of heterosexual sex acts and vaginal intercourse, depending on the sex and genitals the respondents had. Any results or conclusions are valid for homosexual sex acts and anal intercourse, but not necessarily also for heterosexual sex acts or vaginal intercourse. For eventual differences among trans groups please see respective analyses in **Chapter 8**.

Study participants were told: *"In this survey, we use 'sex' to mean physical contact to orgasm (or close to orgasm) for one or both partners.*" They were then asked, *"Have you ever had any kind of sex with a man (please include any sexual contact, not just intercourse)?"* Overall, 98% % indicated *"Yes".*

The chart below shows the age profile of respondents who had not yet had sex compared with the majority who had. It shows that although men who had not yet had sex with a man were disproportionately younger, there were men of all ages taking part in EMIS-2024 who were sexually attracted to men but had not yet had sex with a man.

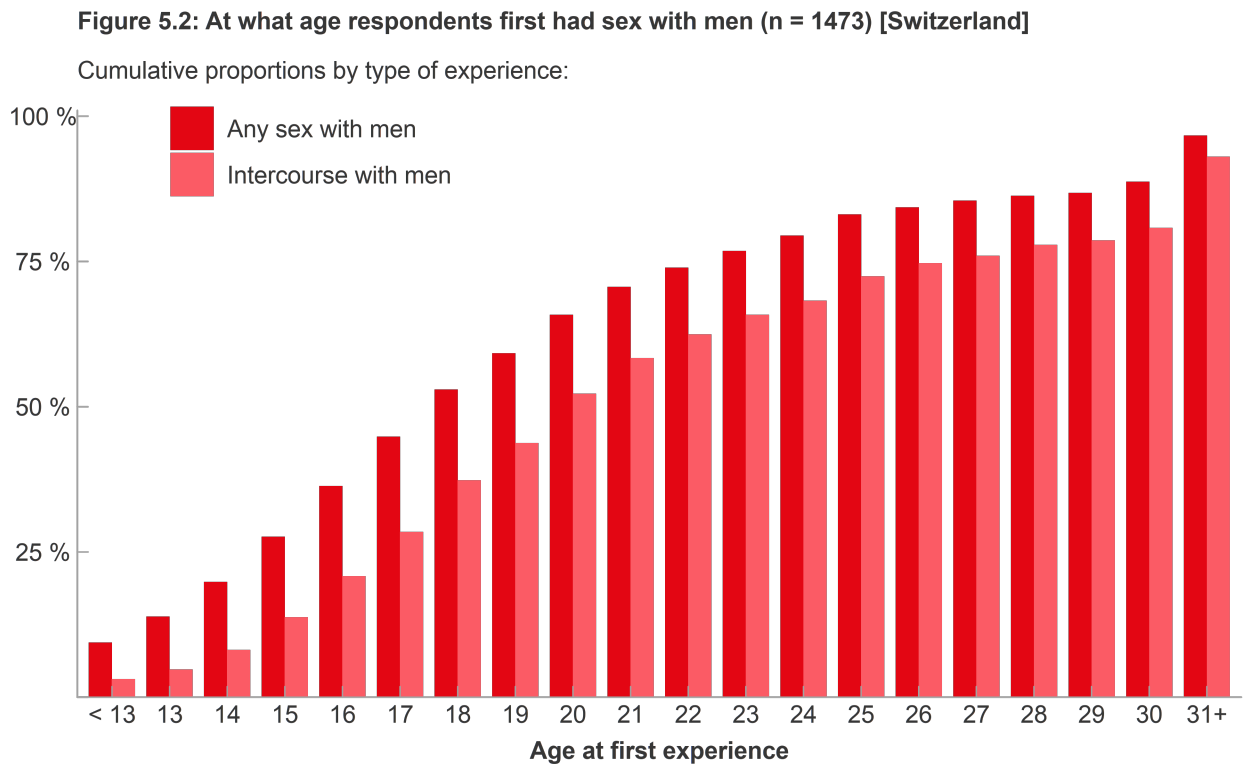
Figure 5.1 Sexual experience with men across age



5.3.1 Age at first sexual experience with a man

Study participants (who had ever had sex with a man) were asked, *"How old were you the very first time you had any kind of sex with another male, or another male had any kind of sex with you?"* Those who had ever had intercourse with a man were asked, *"How old were you the very first time you had intercourse with another male?"* The chart shows the cumulative percentage of respondents who had experienced sex with a man, and intercourse, by each age.

Figure 5.2 At what age respondents first had sex with men



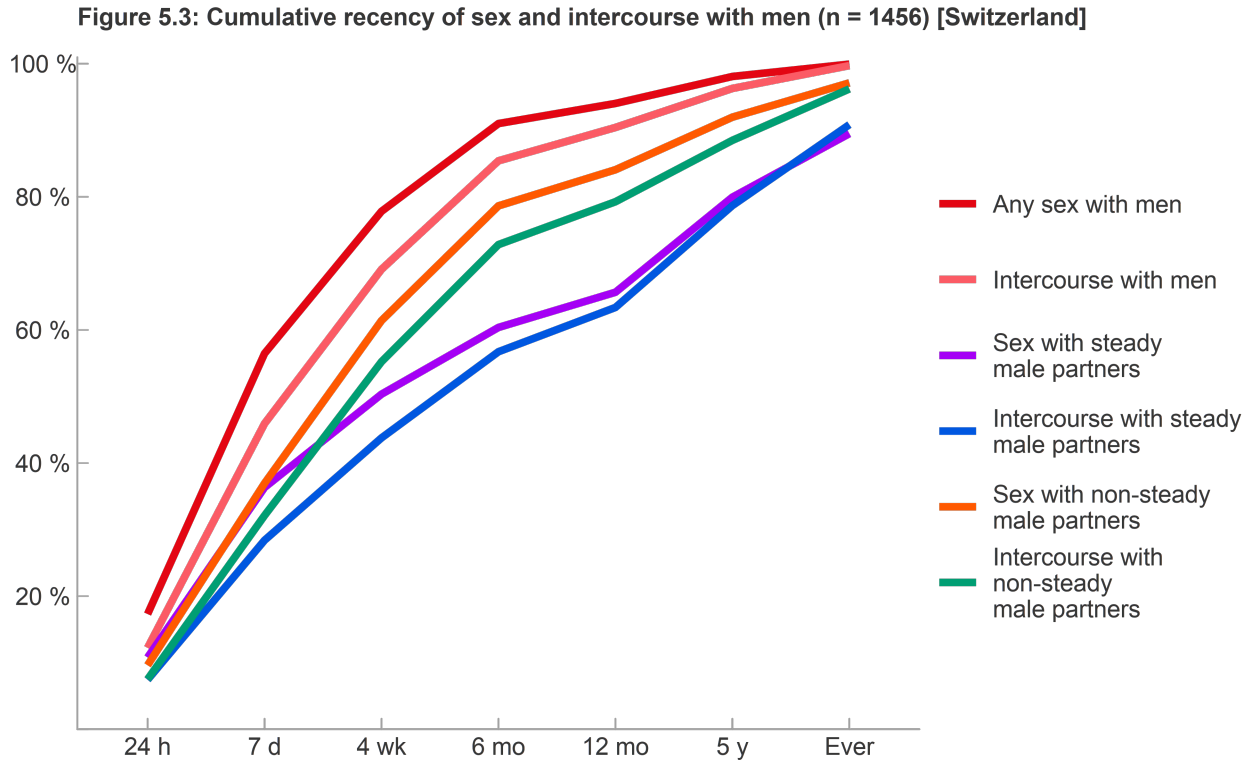
While the median age of first sexual experience was 18 years the median age of first intercourse was 20 years.

5.3.2 Recency of sexual experience with men

Respondents who had ever had sex with a man were asked, "*When did you last have any kind of sex with a steady/a non-steady male partner (please include any sexual contact, not just intercourse)?"* Those who had ever had intercourse with a man were asked, *"When did you last have intercourse with a steady/a non-steady male partner (either with or without a condom)?"* Both questions were also combined for a re-coded variable indicating the recency of sex or intercourse with any male partner. For each question they were offered a scale to indicate how recently intercourse had occurred. Responses are shown below.

While 17.3 % had had sex in the last 24 hours, only12.2 % had engaged in intercourse during that period, suggesting that approximately 70% of sexual sessions between men feature intercourse.

Figure 5.3 Cumulative recency of sex and intercourse with men



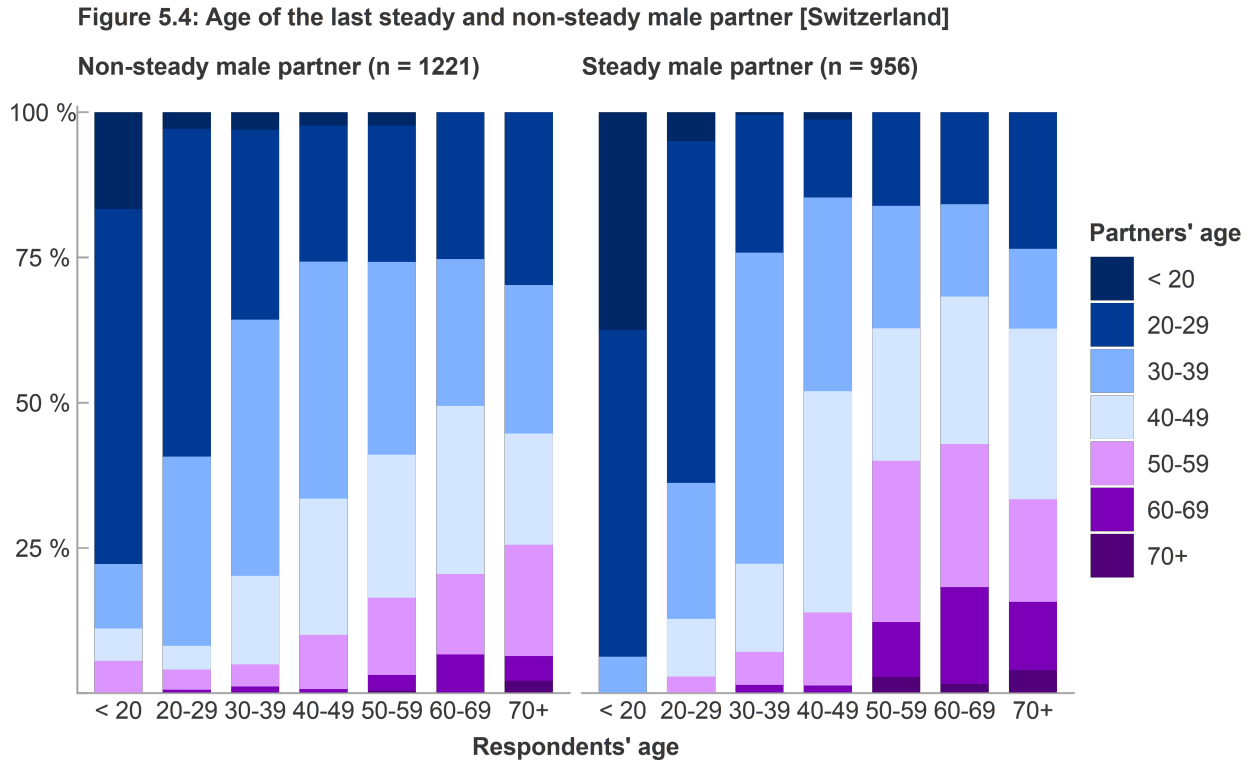
5.3.3 Steady and non-steady partners in the last 12 months

EMIS-2024 followed EMIS-2010 and EMIS-2017 in distinguishing between steady and non-steady sexual partners and asking about them separately. Study participants (who had ever had sex with a man) were told *"In this survey we use the term 'steady partners' to refer to boyfriends or husbands that mean you are not 'single', but not to partners who are simply sex buddies."* They were then asked about steady partners. A little later in the survey they were told *"In this survey we use the term 'non-steady partners' to mean 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)."* They were then asked about non-steady partners.

Study participants were asked separately for steady and non-steady male partners: *"In the last 12 months, have you had any kind of sex with a steady/non-steady male partner?"* Study participants indicating 'Yes' were asked:

- *What was the age of the last steady/non-steady partner that you had sex with? (If there was more than one non-steady partner at that event, think of only one of them). Please give an estimate if you are not sure.*
- *How many different steady/non-steady male partners have you had sex with within the last 12 months?*
- *How many steady/non-steady male partners have you had intercourse with within in the last 12 months?*

Figure 5.4 Age of the last steady and non-steady male partner



5.3.3.1 Numbers of non-steady male partners in the previous 12 months, intercourse and condomless intercourse with these partners

Table 5.5 shows the percentage of men having increasing numbers of non-steady male partners, non-steady male intercourse partners, and non-steady male condomless intercourse partners.

Table 5.5 Numbers of non-steady partners in the last 12 months among respondents who had ever had sex with a man

Numbers of steady male sexual partners in last 12 months (respondents who had ever had sex with a man)	Non-steady male partners* N = 1503 %	Non-steady male intercourse partners** N = 1494 %	Non-steady male condomless intercourse partners*** N = 1478 %
None	19.0	26.8	46.1
1	4.1	6.1	8.5
2	7.0	7.4	6.1
3	8.1	7.8	4.5
4	5.0	4.6	4.2
5	5.5	5.0	3.0
6	3.4	3.9	2.2
7	2.3	1.7	1.2
8	2.9	1.6	1.2
9	0.5	0.3	0.5
10	6.1	5.2	3.0
11-20	14.8	13.0	7.9
21-30	7.8	6.2	4.2
31-40	3.6	2.7	2.0
41-50	2.1	1.9	1.6
More than 50	8.0	6.0	3.9
Total	**100**	**100**	**100**

* Missing n = 6; ** Missing n = 15; *** Missing n = 31

Overall, in the last 12 months, 19 % had no non-steady male partners, 26.8 % had no penetrative non-steady male partners and 46.1 % had no penetrative non-steady male partners with whom they had condomless intercourse. The range of non-steady partners was very wide, with 8 % indicating they had sex with over 50 non-steady male partners in the past year.

5.3.3.2 Recency of sex with steady and non-steady partners

Table 5.6 shows the percentages of respondents (who had ever had sex with a man) with steady and non-steady partners in different time periods.

Table 5.6 Percentages of respondents that had steady and non-steady male partners in different time periods

When did you last have...	..sex with a steady male partner[a] N = 1456	...have intercourse with a steady male partner (with or without condom)[c] N = 1456	...sex with a non-steady male partner[b] N = 1398	...have intercourse with a non-steady male partner (with or without condom)[d] N = 1398
Within the last 24 hours	10.8	7.4	9.6	7.5
Within the last 7 days	25.5	21.0	27.3	24.6
Within the last 4 weeks	14.0	15.4	24.5	23.1
Within the last 6 months	10.0	12.9	17.2	17.6
Within the last 12 months	5.3	6.7	5.4	6.4
Within the last 5 years	14.3	15.3	7.9	9.2
More than 5 years ago	9.5	12.2	5.2	7.7
Never	10.5	9.2	2.9	3.8
Total	**100**	**100**	**100**	**100**

[a] Missing n = 3; [b] Missing n = 4; [c] Missing n = 3; [d] Missing n = 3

According to these questions and responses, 65.6 % had had sex and 63.4 % had had intercourse with a steady male partner in the last 12 months, while 84 % had had sex and 79.2 % had had intercourse with a non-steady male partner.

5.3.4 Risk mitigation during intercourse with non-steady partners

There are different ways to mitigate the risk of HIV transmission when having intercourse with non-steady partners. The most commonly used methods are taking anti-retroviral drugs for treatment of HIV infection (U=U) among people diagnosed with HIV, taking anti-retroviral drugs as chemoprophylaxis for prevention of HIV transmission (HIV-PrEP), using condoms, and HIV sero-sorting (asking about partners' HIV status and having sex only with sero-concordant partners). We asked survey participants: *"What HIV prevention strategy do you use most frequently?"* with the response options shown in **Table 5.7**.

Table 5.7 Most frequently used methods to prevent HIV transmission during intercourse with non-steady partners by HIV diagnosis/PrEP use status (N = 1493); row percentages (rows add up to 100%)

Most frequently used methods to prevent HIV transmission during intercourse with non-steady partners*	I rely on u=U	Condoms	PrEP surfing (I rely on PrEP use of my partner(s))	Asking about HIV status	No particular prevention method	I use PrEP
Diagnosed Diagnosed with HIV n = 142**	65.8	16.4	5.5	2.1	10.3	0.0
Last HIV Test Negative and Taking PrEP** n = 782**	1.4	9.0	2.1	0.9	2.2	85.8
Last HIV Test Negative and not Taking PrEP n = 422	3.1	66.2	5.0	11.4	11.4	2.8
Never Tested for HIV n = 146	5.7	57.4	0.7	10.6	19.1	6.4

* Missing n =4

** Missing n = 0

5.3.5 Use of antiretroviral drugs to prevent HIV transmission during intercourse with non-steady male partners

The use of anti-retroviral drugs to prevent HIV transmission is the most commonly used prevention method among respondents diagnosed with HIV and respondents taking HIV-PrEP. Among respondents diagnosed with HIV the main reason for taking anti-retroviral drugs is the individual health benefit. Among respondents not diagnosed with HIV the use of anti-retroviral drugs as chemoprophylaxis (HIV-PrEP) has gained popularity in recent years. Particularly daily use of HIV-PrEP is frequently associated with high partner numbers.

5.3.6 Condom use during intercourse with non-steady male partners

Study participants who had a non-steady male intercourse partner in the last 12 months were asked, "*In the last 12 months, how often were condoms used when you had intercourse with non-steady male partners?*" The responses offered and the percentage of respondents indicating each is given in **Table 5.9**.

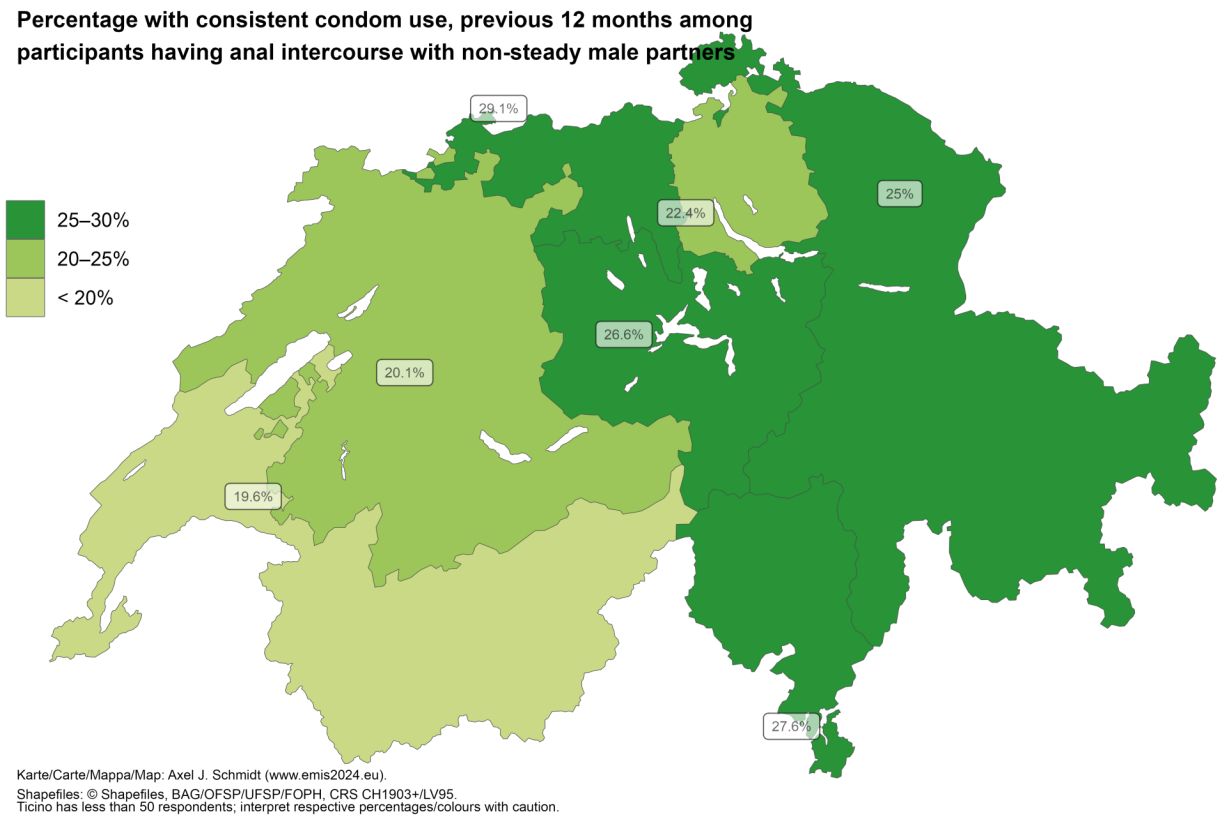
Table 5.9 Condom use for intercourse with non-steady partners in last 12 months

In the last 12 months, how often were condoms used when you had intercourse with non-steady male partners?* N = 1093	%
Never	19.6
Seldom	18.5
Sometimes	14.0
Mostly	16.9
Always	21.0

* Missing n = 0

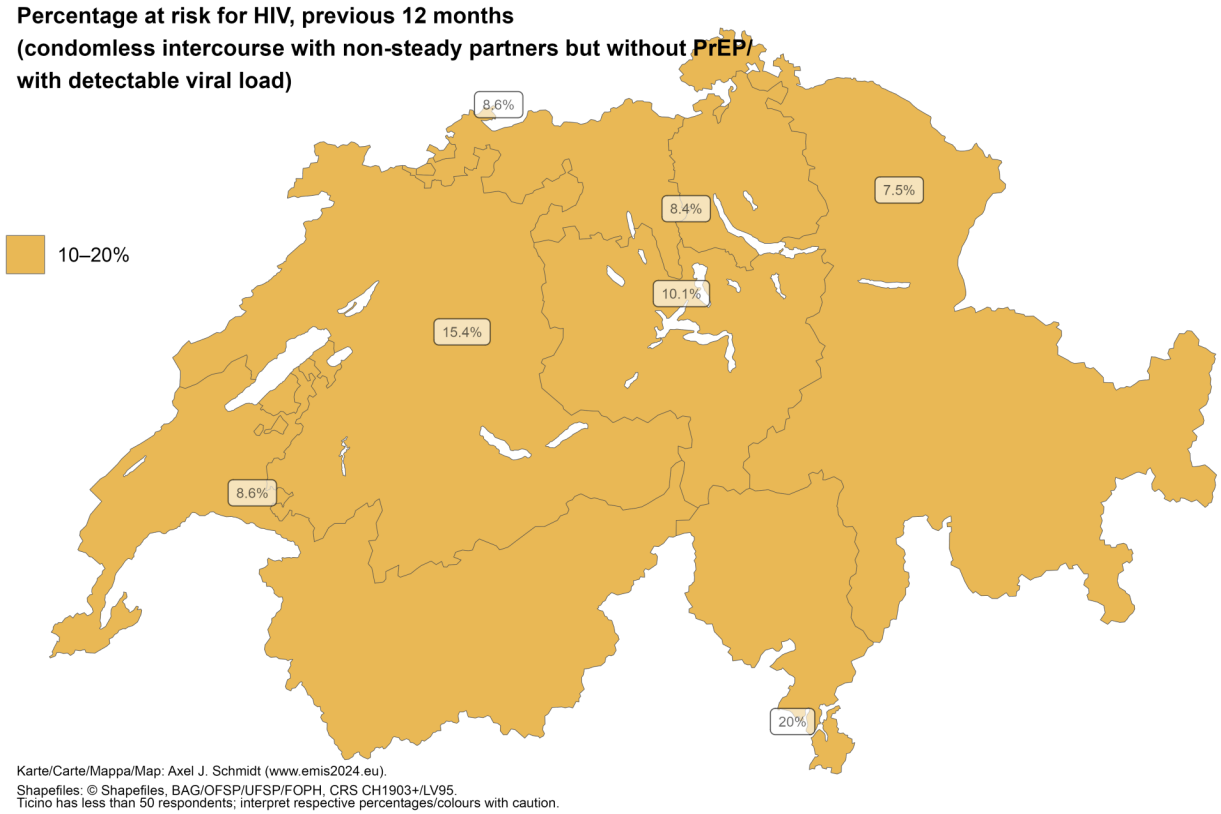
The majority (80.4 %) of respondents who had intercourse with non-steady partners in the last 12 months had some experience of condom use, suggesting that condoms are still common during intercourse with non-steady partners. However, consistent use is not the norm, with 21 % of respondents (who had intercourse with non-steady partners) being consistent users.

Map 5.2 Percentage with consistent condom use, previous 12 months, among respondents having anal intercourse with non-steady partners



As the comparison with **Map 5.1** shows, taking HIV PrEP has replaced condoms as the preferred method to reduce the risk of getting HIV to a certain extent in Switzerland. The following **Map 5.3** shows the proportions of survey participants per country who neither used consistently condoms nor took HIV PrEP nor were treated for HIV with anti-retroviral drugs and had intercourse with non-steady partners of unknown HIV status.

Map 5.3 Percentage who used neither condoms nor HIV PrEP nor were treated for HIV with anti-retroviral drugs and had anal intercourse with non-steady male partners of unknown HIV status in the last 12 months



Karte/Carte/Mappa/Map: Axel J. Schmidt (www.emis2024.eu).
Shapefiles: © Shapefiles, BAG/OFSP/UFSP/FOPH, CRS CH1903+/LV95.
Ticino has less than 50 respondents; interpret respective percentages/colours with caution.

5.3.7 Other methods of risk mitigation in condomless intercourse with non-steady male partners

Not all condomless intercourse with non-steady partners among people not taking anti-retroviral drugs carries the same risk of HIV transmission. Some risk mitigation tactics used by MSM under these circumstances have been identified. These include sero-sorting (avoiding condomless intercourse except with partners known to have the same HIV status), having condomless intercourse with HIV positive partners only when they are known to have undetectable viral load, and having condomless intercourse with HIV negative partners only when they are on PrEP.

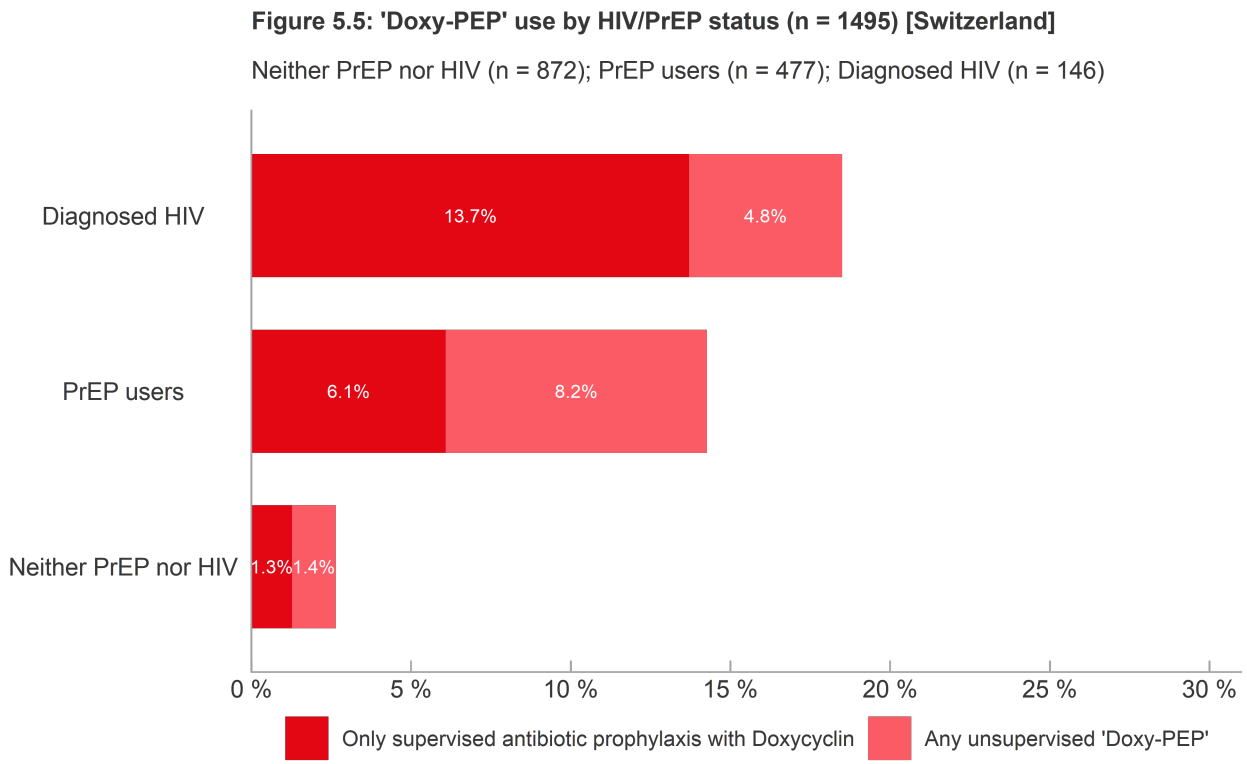
These percentages were different among respondents taking anti-retroviral drugs for treatment, as PrEP, or not, as shown in **Table 5.10**.

Table 5.10 Intercourse and condomless intercourse (and frequency of condom use) with non-steady partners in the last 12 months for respondents living without diagnosed HIV and not using HIV PrEP, respondents using HIV-PrEP, and respondents with diagnosed HIV

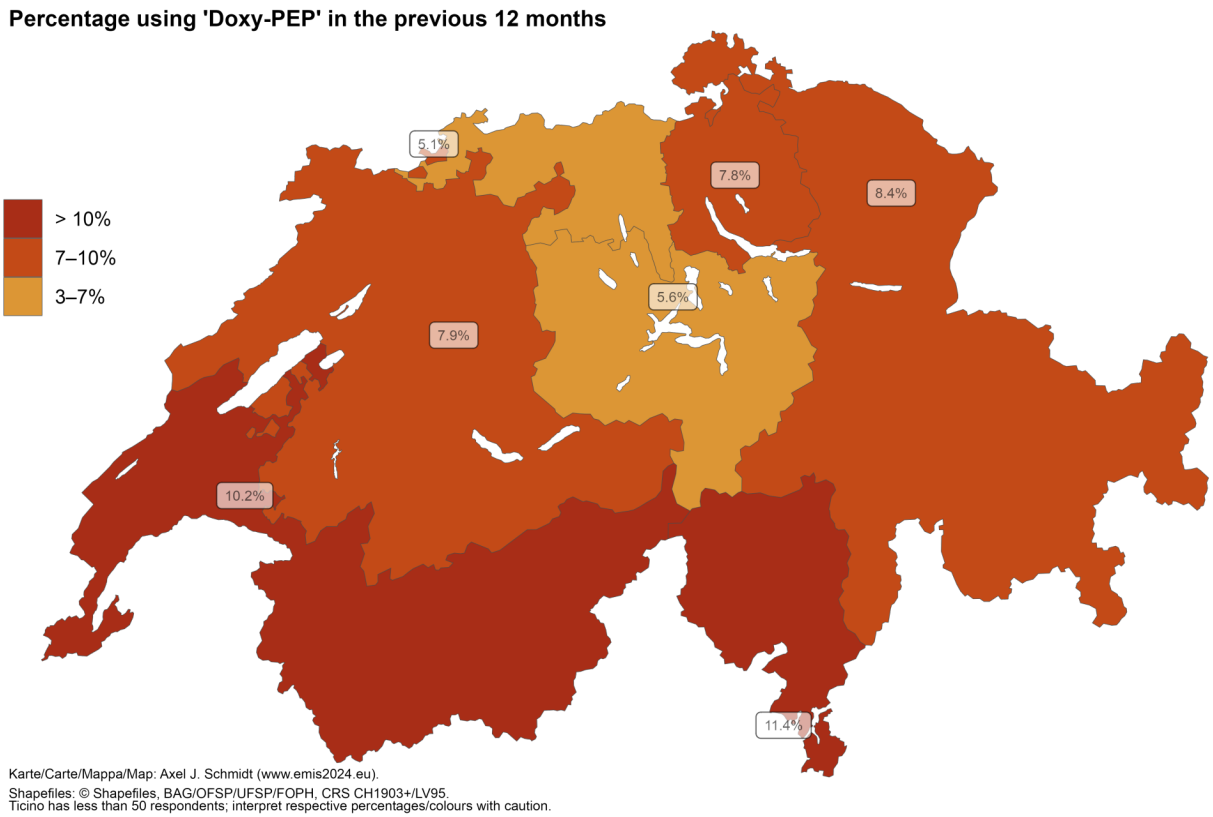
Sexual behaviour measure	Respondents not diagnosed with HIV and not taking PrEP	Respondents not diagnosed with HIV and taking PrEP	Respondents diagnosed with HIV
Any sex with a non-steady male partner in the previous 12 months	100.0	100.0	100.0
Any intercourse with a non-steady male partner in the previous 12 months (of those who had sex with a non-steady male partner)	98.0	99.5	99.2
Any condomless intercourse with a non-steady male partner in the previous 12 months (of those who had intercourse)	53.3	91.5	91.8
Not always condom use with a non-steady male partner in the previous 12 months (of those who had intercourses)	58.3	93.8	95.1
Intercourse without a condom with a non-steady partner whose HIV status you did not know or think about at the time (of those who had condomless intercourse)	55.2	23.1	20.5

5.4 Antibiotic STI-prophylaxis (“Doxy-PEP”)

Figure 5.5: ‘Doxy-PEP’ use by HIV/PrEP status



Map 5.4 Percentage using antibiotic prophylaxis for STIs



5.5 Sexual repertoire

All study participants who reported sex with non-steady partners were asked, *"Thinking about the sex you've had with non-steady male partners only, how long has it been since you engaged in each of the following? (please say when you last did something, even if this was not typical for you)"*, with the response options

(3) mutual masturbation,

(4) sucking a man's penis,

(5) get one's penis sucked,

(6) lick a man's anus,

(7) have a man lick one's anus,

(8) have "active" anal intercourse,

(9) have "passive" anal intercourse,

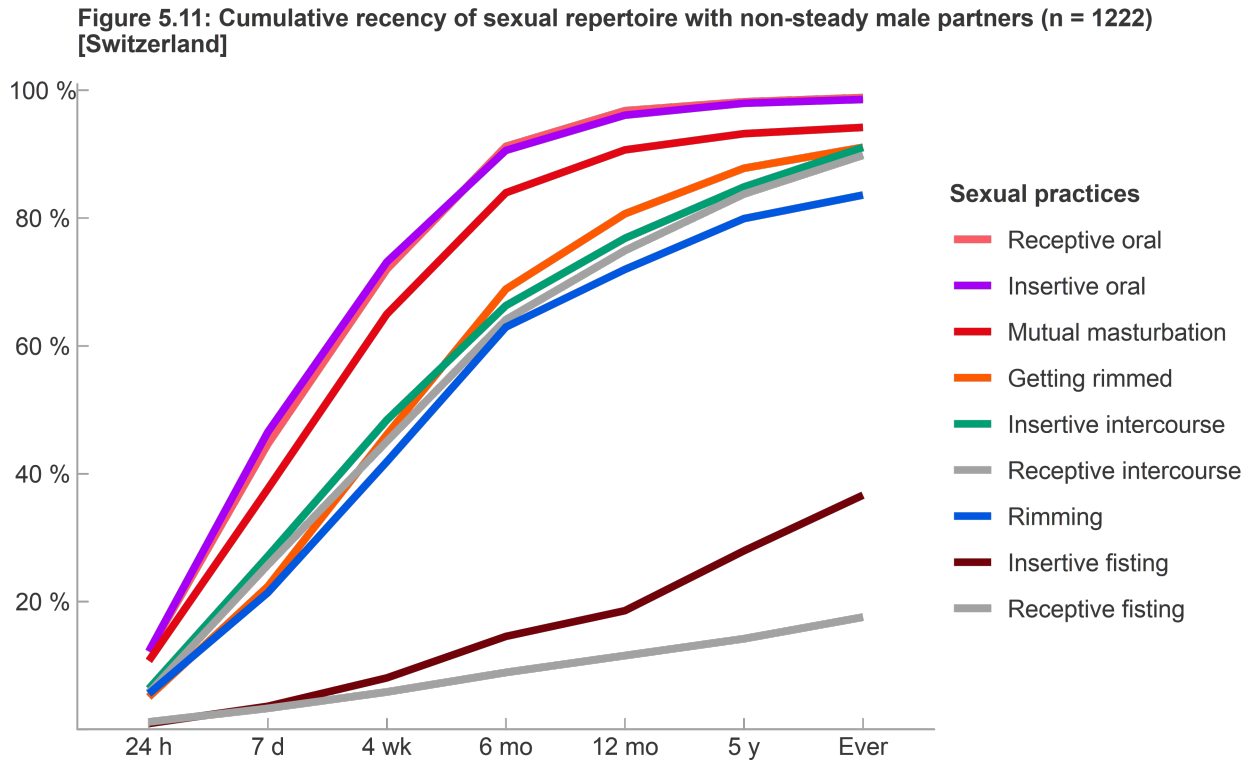
(10) put one's hand in a man's rectum,

(11) have a man's hand in one's rectum.

The recency of the different behaviours is shown as a recency curve. Survey participants who elsewhere had indicated having a vagina instead of a penis were asked additional questions about receptive vaginal intercourse and fisting, which are not displayed here but only in **Chapter 8**.

Oral sex had the highest recency, followed by mutual masturbation, rimming, and anal sex. Fisting had the lowest recency.

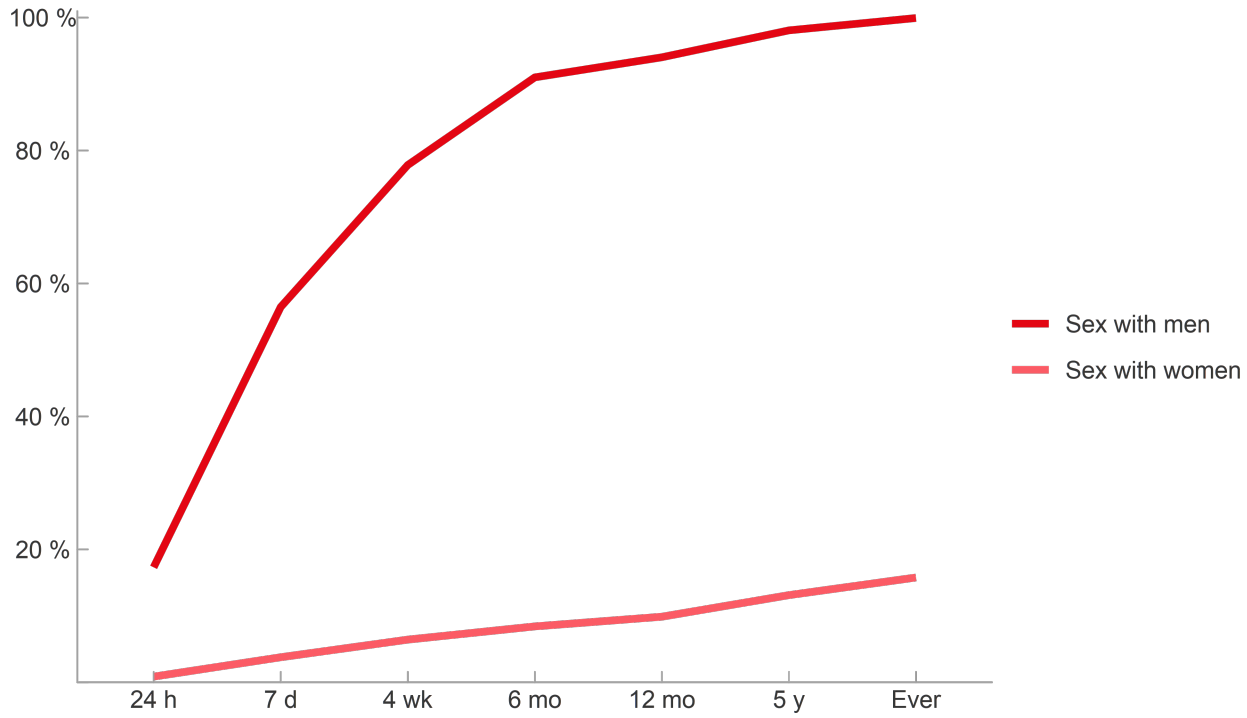
Figure 5.11 Cumulative recency of sexual repertoire with non-steady male partners



5.6 Sex with women

Study participants were reminded that “In this survey, we use ‘sex’ to mean physical contact to orgasm (or close to orgasm) for one or both partners.” Study participants were asked, *“When did you last have any kind of sex with a woman?”* and offered a scale for indicating how recently this occurred. Since the question regarding the recency of sex with women was in 2024 only displayed to participants who indicated they were attracted to women—consequently,the curve cannot be compared to the respective one from EMIS-2017, where all participants received this question.

Figure 5.12: Cumulative recency of sex with men and women (n = 1509) [Switzerland]



5.7 Substance use

The collection of valid data on both licit and illicit drug use is difficult and may be particularly problematic in self-completed, retrospective, large multi-language/national surveys. These problems may result in underreporting or misreporting of drug use. The problems vary depending on the data being sought and the questions being asked. Asking about drug use was a key priority of the EMIS Network.

5.7.1 Use of legal drugs

All study participants were asked, *“When was the last time you consumed…”* followed by five different drugs which are not illegal to possess in most of Europe: alcohol; tobacco products; poppers (nitrite inhalants); Viagra, Cialis, Levitra or other substances that help to get or keep an erection; sedatives or tranquilisers (Valium, Rivotril, Rohypnol, Xanax, Seduxen, Phenazepam). We did not investigate whether erection-enhancing drugs or sedatives were prescribed or not.

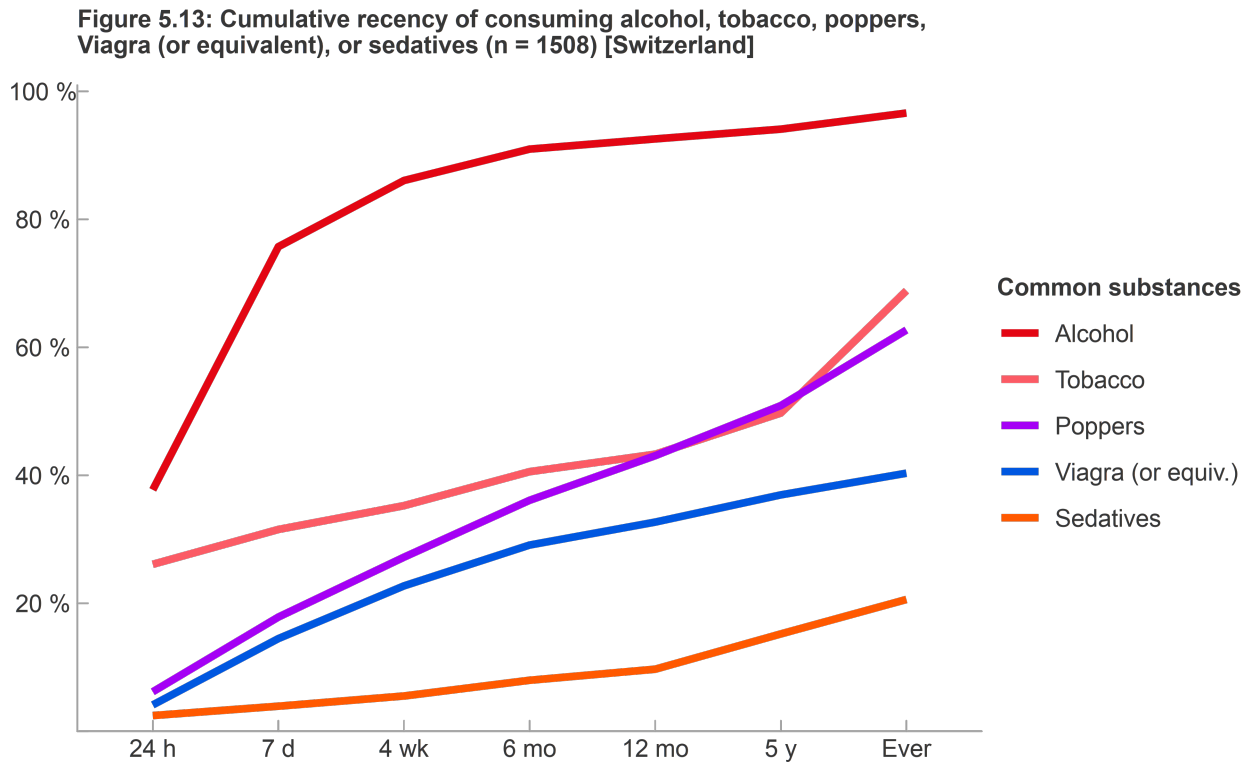
Table 5.14 shows the cumulative percentages for those who had used each drug within extending time periods. The bottom two rows also show the percentage of respondents having ever taken the drug who had taken it in the last 12 months (an indicator of the proportion of users who had quit the drug), and the percentage of respondents who had taken it in the last 12 months who had taken it in the last seven days (an indicator of the frequency of drug use in the population of users).

Table 5.14 Recency of specific substance use

Cumulative %	Alcohol	Tobacco products	Poppers	Viagra etc.	Sedatives etc.
Within the last 24 hours	37.7	26.1	6.2	4.1	2.5
Within the last 7 days	75.7	31.5	17.9	14.5	3.9
Within the last 4 weeks	86.1	35.3	27.2	22.7	5.5
Within the last 6 months	91.0	40.6	36.1	29.1	8.0
Within the last 12 months	92.6	43.3	43.1	32.7	9.7
Within the last 5 years	94.1	49.7	50.9	36.9	15.2
Ever	96.6	68.9	62.7	40.3	20.6
7 days as a fraction of 12 months	81.7	72.7	41.5	44.3	40.2
12 months as a fraction of ever	95.8	62.9	68.7	81.1	47.1

Figures 5.13–5.15 present these data graphically, showing the cumulative percentages for those having used each of the drugs during their lifetime.

Figure 5.13 Cumulative recency of consuming alcohol, tobacco, poppers, Viagra (or equivalent), or sedatives



5.7.2 Use of illicit drugs

After being asked about drugs that are not illegal to possess, all respondents were then asked, *“Have you ever taken any other recreational or illicit drugs?”* Overall, 45.9 % answered *"Yes"*. Those who answered *"Yes"* were asked, *“When was the last time you consumed…”* followed by the 14 types of illicit drugs below:

- Cannabis (hashish, marijuana)
- Synthetic cannabinoids (e.g. Spice, K2, herbal incense)
- Ecstasy (E, XTC, MDMA) in the form of a pill, crystal or powder
- Amphetamine (speed)
- Crystal methamphetamine (crystal, meth, Tina, Pervitin)
- Heroin or related drugs (poppy straw, kompot, fentanyl)
- Mephedrone (4-MMC, meow, methylone, bubbles)
- Synthetic stimulants other than mephedrone (e.g. MXE, bath salts, 3-MMC, 4-MEC, 4_FA, XTC-light)

- Alpha Php
- GHB/GBL (liquid ecstasy)
- Ketamine (special K)
- LSD (acid)
- Cocaine
- Crack cocaine.

For each drug respondents were offered a scale to indicate how recently they had used it. It should be noted that the questions referred to each drug separately and poly drug use (combining drugs) was not measured. **Tables 5.15** and **5.16** show the cumulative percentage of respondents who had used each drug within each time frame. The bottom two rows also show the percentage of those ever having used a drug who had taken it in the last 12 months (an indicator of the historic nature of drug use), and the percentage having taken a drug in the last 12 months who had taken it in the last seven days (an indicator of the frequency of drug use among users).

Table 5.15 Recency of illicit or recreational drug use, part 1

Cumulative %	Cannabis	Ecstasy	Ampheta-mines	Synthetic stimulants	Alpha PhP	GHB / GBL	Co-caine
Within the last 24 hours	5.3	0.2	0.1	0.3	0.0	0.5	0.7
Within the last 7 days	9.1	1.5	0.4	1.6	0.1	1.8	2.2
Within the last 4 weeks	12.8	3.4	0.5	2.5	0.2	3.0	4.2
Within the last 6 months	19.2	8.6	1.6	4.4	0.2	4.9	8.8
Within the last 12 months	24.1	11.9	2.5	5.7	0.2	7.0	12.5
Within the last 5 years	31.4	17.2	4.3	7.4	0.5	10.5	17.8
Ever	43.4	23.3	7.4	7.6	0.5	14.0	24.0
7 days as a fraction of 12 months	37.8	12.6	16.0	28.1	50.0	25.7	17.6
12 months as a fraction of ever	55.5	51.0	34.0	74.7	37.7	49.8	52.1

Table 5.16 Recency of illicit or recreational drug use, part 2

Cumulative %	Synthetic canna-binoids	Crystal meth	Heroin	Mephedrone	Ketamine	LSD	Crack
Within the last 24 hours	0.2	0.3	0.1	0.3	0.5	0.1	0.1
Within the last 7 days	0.3	1.4	0.1	1.1	1.3	0.5	0.3
Within the last 4 weeks	0.4	2.5	0.2	2.1	2.1	1.1	0.3
Within the last 6 months	1.2	4.2	0.3	3.9	4.1	3.2	0.6
Within the last 12 months	1.7	5.7	0.3	4.8	6.0	5.4	0.8
Within the last 5 years	2.5	8.0	0.7	6.3	9.0	8.4	1.3
Ever	3.9	9.6	2.0	6.9	11.5	13.3	2.0
7 days as a fraction of 12 months	17.6	24.6	33.3	22.9	21.7	9.3	37.5
12 months as a fraction of ever	43.5	59.2	15.1	69.4	52.0	40.7	40.2

Figure 5.14 Cumulative recency of consuming illicit substances

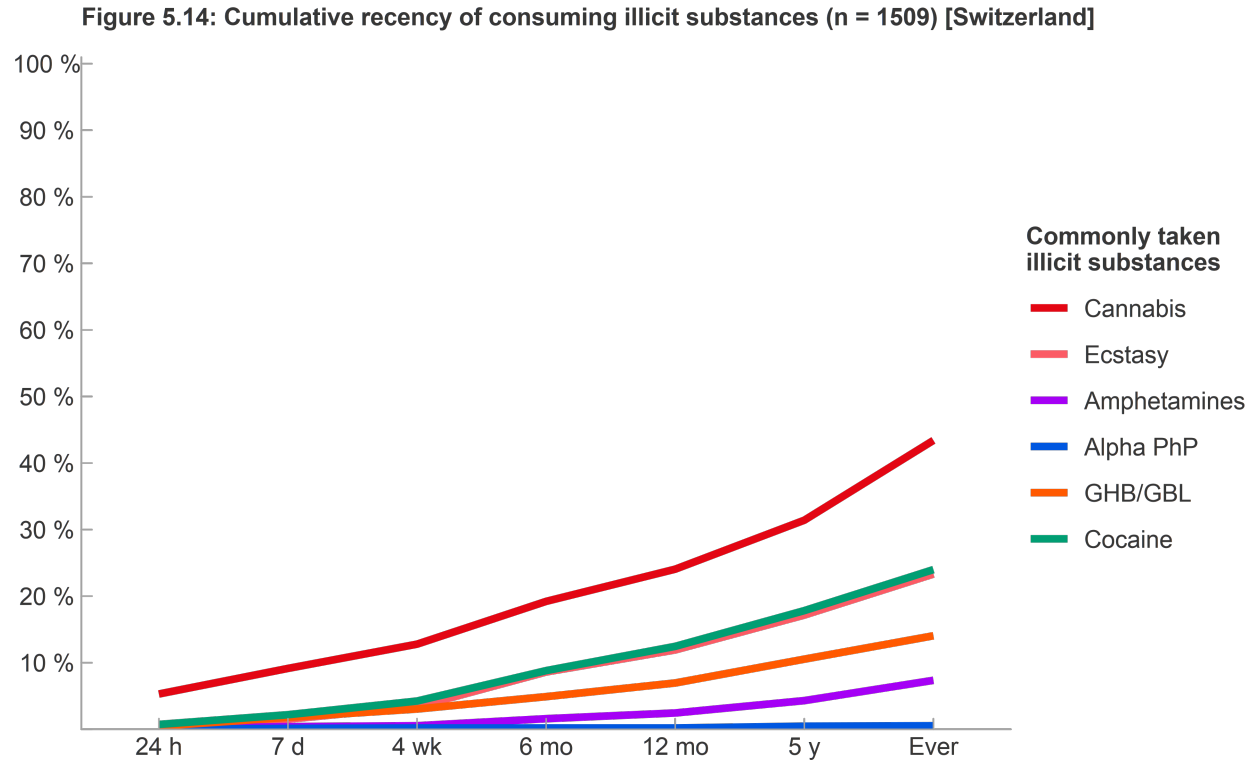
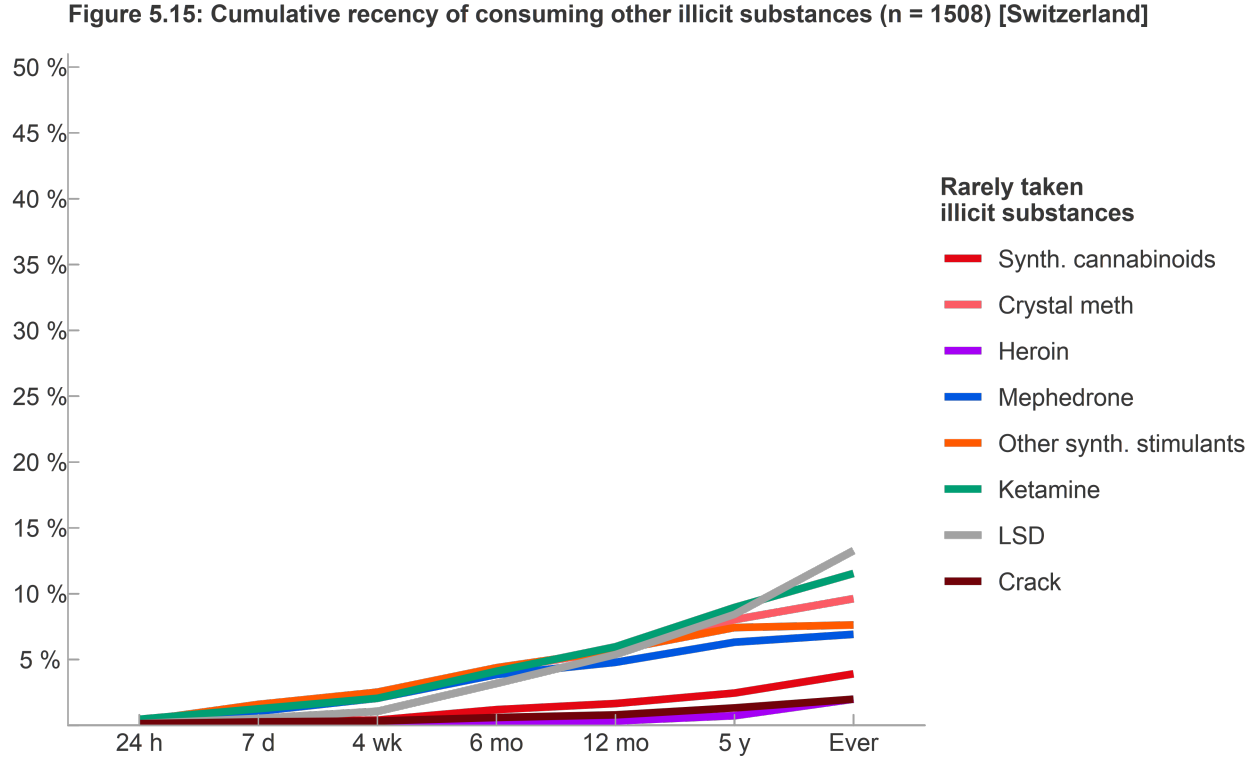


Figure 5.15 Cumulative recency of consuming other illicit substances



5.7.3 Injecting drugs

Historically, in Switzerland at least, injecting drugs has been uncommon among MSM taking part in community surveys. This may have changed recently with the increase in chemsex.

All respondents were asked, *"Have you ever injected anabolic steroids (testosterone), or had someone else inject into you?"* and were offered the responses: No, never; Yes, within the last 12 months; Yes, more than 12 months ago. This question captures both prescribed and non-prescribed drugs and it is possible some respondents confused corticosteroids administered by healthcare workers with anabolic steroids.

Respondents were also asked, *"Have you ever injected any drug to get high (other than anabolic steroids or prescribed medicines), or had someone else inject into you?"* with the same response set.

Table 5.17 Injecting drug use

Have you ever injected or had someone else inject into you…?	% anabolic steroids (testosterone)	% any drug to get high (other than anabolic steroids or prescribed medicines)
No, never	98.7	96.5
Yes, more than 12 months ago	0.8	1.5
Yes, within the last 12 months	0.5	2.0

5.7.3.1 Frequency of injecting

Study participants who had injected drugs to get high in the last 12 months were asked, *"In the last 12 months how many times have you injected any drug other than anabolic steroids or medicines, or had someone else inject into you?"* and were offered the numbers 1 to 9 followed by *"10 or more".*

Table 5.18 Frequency of injecting drugs to get high in the last 12 months

Frequency of injecting to get high in last 12 months	% of respondents who had injected to get high in the last 12 months	Cumulative % of respondents who had injected to get high in
1	27.6	27.6
2	6.9	34.5
3	10.3	44.8
4	6.9	51.7
5	6.9	58.6
6	3.4	62.0
7		
8	3.4	65.4
9		
More than 10	34.5	99.9

5.7.3.2 Drugs being injected

Respondents who had injected in the last 12 months (n = 30) were asked, *"Which drugs have you injected or had injected into you in the last 12 months?"* and instructed to tick all that applied from the list of drug types in **Table 5.19**.

Table 5.19 Drugs injected in the last 12 months among men who have injected to get high

Which drugs have you injected or had injected into you in the last 12 months?	% of respondents who injected to get high in last 12 months
Crystal methamphetamine (crystal, meth, Tina, Pervitin)	(62.1)
Synthetic stimulants other than mephedrone (eg. MXE, bathsalts, 3MMC, 4MEC, 4_FA, XTClight)	(51.7)
Mephedrone (4MMC, meow, methylone, bubbles)	(13.8)
Cocaine	(13.8)
Ecstasy (E, XTC, MDMA)	(3.4)
Amphetamine (speed)	(3.4)
Heroin or related drugs (poppy straw, kompot, fentanyl)	(3.4)
Ketamine (special K)	(6.9)
Alpha PhP	(3.4)
Crack cocaine	(0.0)
I've injected drugs but I don't know which drugs	(3.4)

5.7.1 Combining sex and drugs

Chemsex is a major concern that has emerged since EMIS-2010. Defining chemsex and developing an acceptable measure that was appropriate across cultures was a major challenge. We decided not to use the word 'chemsex' in the survey itself and to ask a series of both broader and narrower questions.

Men who had had sex with a man in the last 12 months 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?"* and were offered the responses in **Table 5.21**.

Table 5.21 Percentage of all sex with men that has been under the influence of alcohol or any other drug in the last 12 months

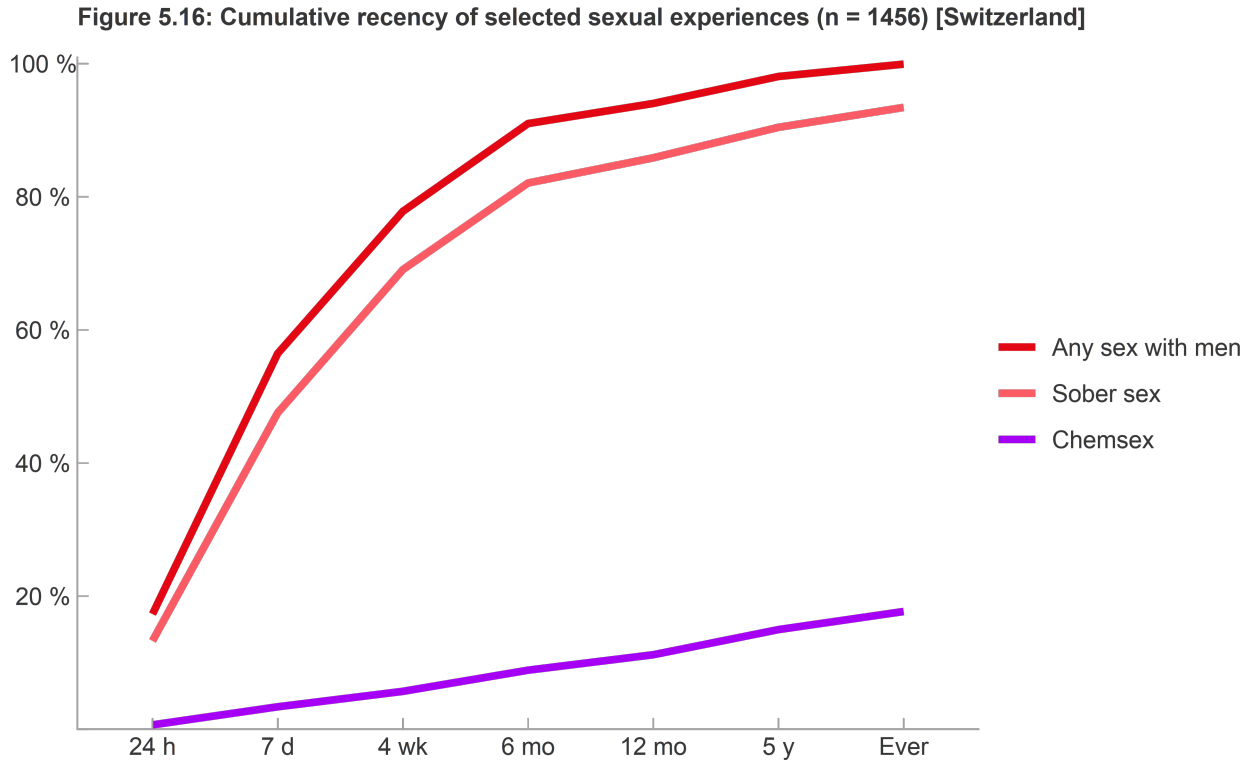
Percentage of all sex with men that has been under the influence of alcohol or any other drug in the last 12 months	%
About half	6.2
All of it	1.8
Almost all of it	4.6
Almost none of it	29.9
Less than half	12.4
More than half	4.4
None of it	40.7
Total	**100**

5.7.2 Recency of sober sex and chemsex

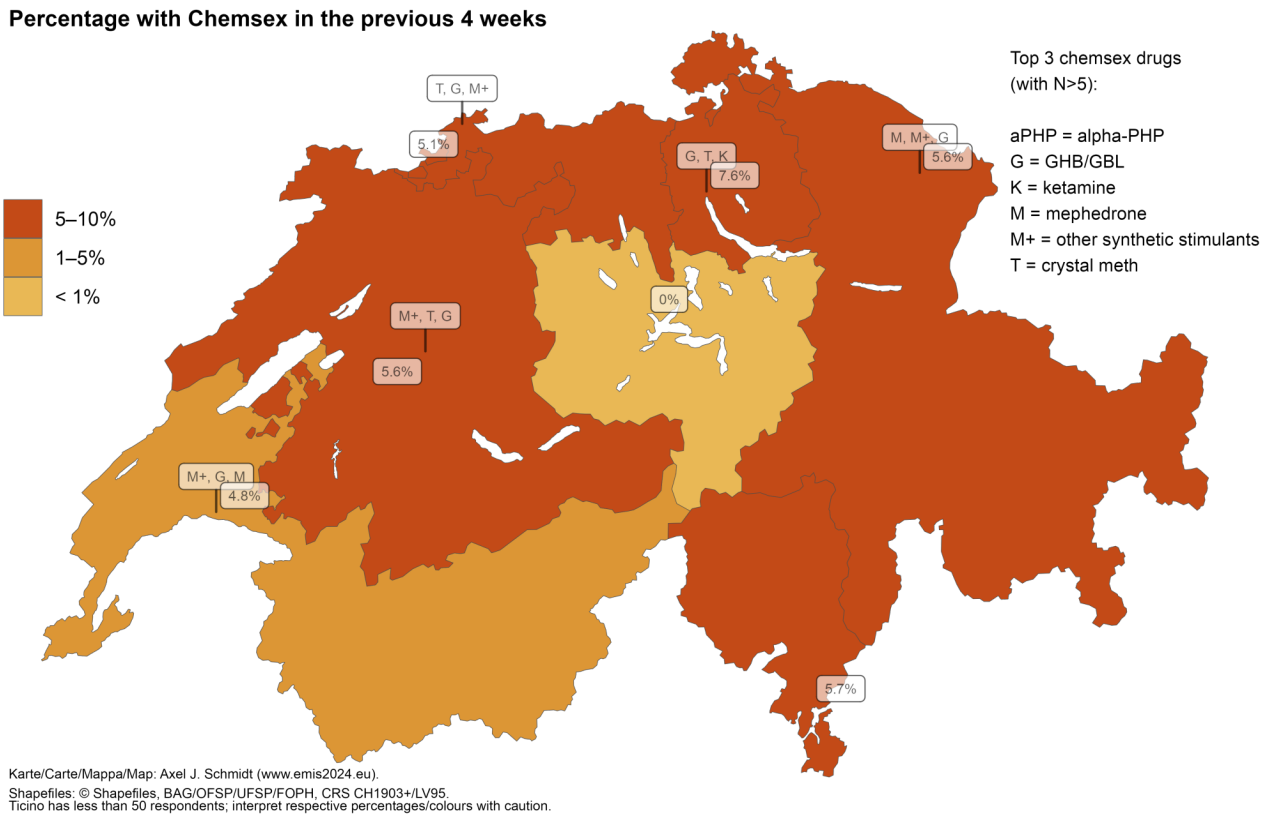
All study participants were asked, *"When was the last time you had sober sex (that is, NOT under the influence of alcohol or any other drug)?"* and were offered a scale to indicate how recently this had occurred. They were also asked, *"When was the last time you used stimulant drugs to make sex more intense or last longer? (Note: the stimulant drugs include ecstasy/MDMA, cocaine, amphetamine (speed), crystal methamphetamine (Tina, Pervitin), mephedrone and ketamine)"* and were offered a scale to indicate how recently this had occurred. It should be noted that ketamine has hallucinogenic, dissociative and anaesthetic effects and is a stimulant only in small doses. The behaviour defined in this last question will, for ease of reference, hereafter be referred to as 'chemsex'. Chemsex is a recently emerged category of behaviour among MSM for which there is no agreed definition.

While all definitions include the combining of sex and substances, not all sex under intoxication is considered chemsex. Other necessary features of a chemsex definition may include sex between men (*i.e.,* only male homosex can be chemsex); sex between casual partners and/or fuck-buddies (*i.e*., not between those romantically involved); facilitation by smartphone dating apps; use of specific drugs, typically GHB/GBL, crystal methamphetamine, mephedrone, and/or ketamine); extended duration; a climate of shame, marginalisation and trauma based on the history of the HIV epidemic and internalised homophobia among gay and bisexual men. We choose to focus our measurement on intentional use of stimulant drugs for intensification and extension of sex. We recognise this is not a definitive measurement of chemsex (there can be no such thing) but it has the benefit of precision and clarity. The figure shows the responses, superimposed on the recency of any sex with men and the recency of intercourse with men.

Figure 5.16 Cumulative recency of selected sexual experiences



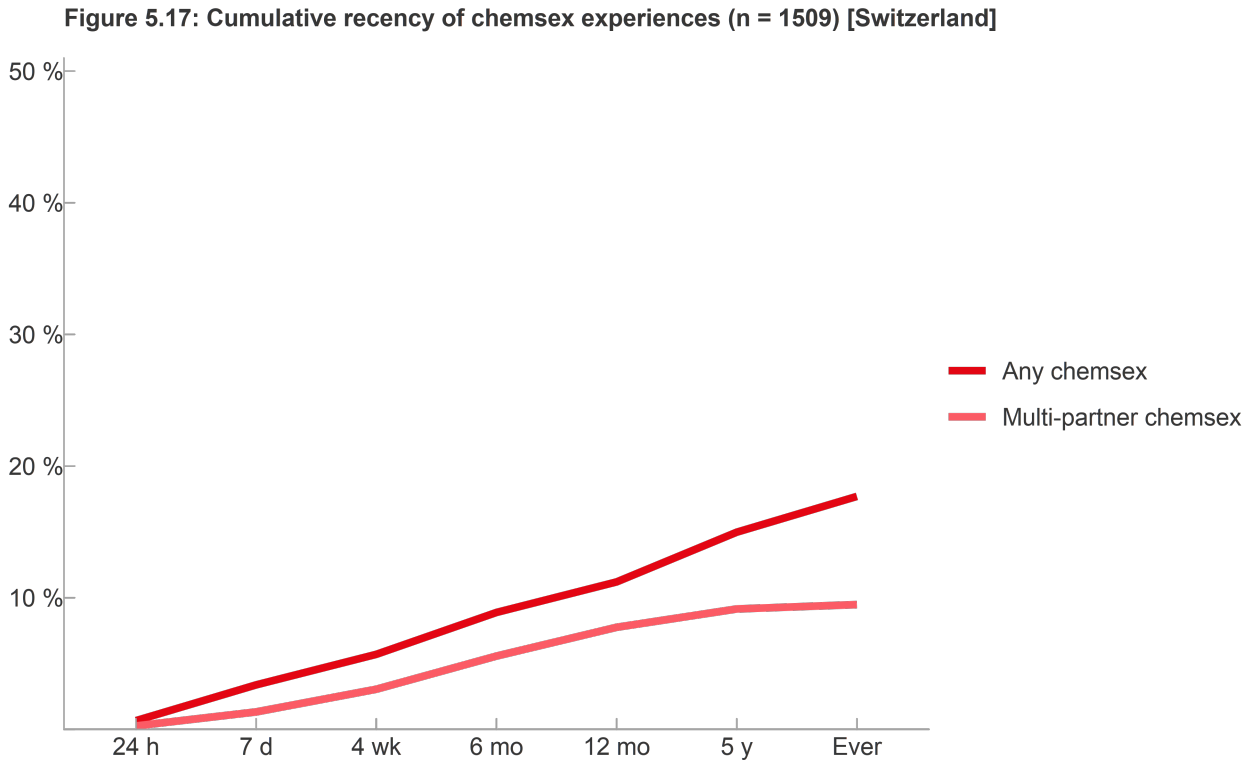
Map 5.5 Percentage who used stimulant drugs to make sex more intense or last longer (chemsex), last four weeks



5.7.3 Features of chemsex

Respondents who had ever had chemsex were asked, *"When was the last time you combined stimulant drugs and sex with more than one man at the same time?"* and were offered a scale to indicate how recently this had occurred. We refer to this behaviour as "multi-partner chemsex". The figure shows the recency for multi-partner chemsex superimposed on the recency for any chemsex.

Figure 5.17 Cumulative recency of chemsex experiences



Study participants who had chemsex with multiple partners in the last 12 months were asked, *"Where did that most recent sex with stimulants and multiple partners take place?"* and given the responses below.

Table 5.22 Location of most recent sex with stimulants and multiple partners among men who had multi-partner chemsex in the last 12 months

Location of most recent sex with stimulants and multiple partners among respondents who had multipartner chemsex in the last 12 months	%
Your home	20.5
Someone else's home	47.9
A hotel room	6.0
In a club or backroom of a bar	14.5
A sauna	4.3
A porn cinema	
A cruising location (street, roadside service area, park, beach, baths, lavatory)	2.6
Other answer	4.3

Regional variation in behaviour

Table 5.23a Regional variation in key behaviour

Qualifying cases	Switzerland	% taking ART*	% who ever took PEP**	% taking PrEP**	% using antibiotics for STI prophylaxis***
1 509	**Overall Total**	**100**	**15.8**	**32.1**	**8**
	Regions				
313	Région lémanique	(100)	13.2	33.2	10.2
266	Espace Mittelland	(100)	17	27.7	7.9
197	Nordwestschweiz	[100]	15.3	22.2	5.1
486	Zürich	(100)	18.2	39	7.8
107	Ostschweiz	[100]	15.7	34	8.4
89	Zentralschweiz	[100]	(13.4)	(31.7)	(5.6)
35	Ticino	[100]	(6.7)	(10)	(11.4)
	Cities				
262.0	Zürich	(100)	22.9	46.4	10.7
157.0	Geneva-Lausanne	[100]	18	39.6	14.6

Numbers in parentheses ( ) indicate that the total number of respondents for that category is less than 100 (N < 100).
Numbers in brackets [ ] indicate that the total number of respondents is less than 20 (N < 20). * among HIV-diagnosed; ** excluding HIV-diagnosed; *** took antibiotics in the last 12 months
(e.g., doxycycline) before or after having sex to reduce the risk of getting some sexually transmitted infections. (Doxy PrEP/Doxy-PEP)'

Table 5.23b Regional variation in key behaviour (continued)

Qualifying cases	Switzerland	Number (median) of NON-STEADY male sex partners	% with condomless intercourse with NON-STEADY male partners of unknown HIV status, last 12m	% injecting drugs*	% engaging in chemsex**
1 509	**Overall Total**	**6**	**36.3**	**2**	**5.7**
	Regions				
313	Région lémanique	6	35.8	2.2	4.8
266	Espace Mittelland	5	36.1	2.3	5.6
197	Nordwestschweiz	5	25.9	1	5.1
486	Zürich	8	41.2	2.5	7.6
107	Ostschweiz	6	37.4	2.8	5.6
89	Zentralschweiz	5	(33.7)	(0)	(0)
35	Ticino	10	(37.1)	(0)	(5.7)
	Cities				
262	Zürich		46.9	3.4	8.4
157	Geneva-Lausanne	10	46.5	1.9	6.4

Numbers in parentheses ( ) indicate that the total number of respondents for that category is less than 100 (N < 100).
Numbers in brackets [ ] indicate that the total number of respondents is less than 20 (N < 20). * excluding steroids, last 12 months; ** defined as using stimulant drugs to make sex more intense or last longer, last 4 weeks

Table 5.23c Regional variation in key behaviour (continued)

Qualifying cases	Switzerland	% reporting last NON-STEADY male partner sex involving 2 or more people	% who met their last NON-STEADY male partner online	% using a mobile phone app for partner acquisition	% with last NON-STEADY male partner sex in a gay sex venue or cruising location	% using u=U or PrEP for prevention of HIV transmission, last encounter, excluding men without AI
1 509	**Overall Total**	**18.1**	**9**	**48.6**	**17**	**43.8**
	Regions					
313	Région lémanique	21.5	7.3	50.8	16	43.7
266	Espace Mittelland	15.7	7.5	47.7	15.4	37.6
197	Nordwestschweiz	14.6	11.7	48.7	14.7	34
486	Zürich	16.4	8.4	50.6	15.6	51.9
107	Ostschweiz	(19.8)	10.3	41.1	21.5	(50)
89	Zentralschweiz	(17.4)	(11.2)	(40.4)	(30.3)	(45.3)
35	Ticino	(46.7)	(20)	(51.4)	(22.9)	(13.8)
	Cities					
262	Zürich	15.9	6.9	51.5	15.3	57.6
157	Geneva-Lausanne	23.7	9.6	52.9	15.3	47.3

Numbers in parentheses ( ) indicate that the total number of respondents for that category is less than 100 (N < 100).
Numbers in brackets [ ] indicate that the total number of respondents is less than 20 (N < 20).

Chapter 6: Needs

We define sexual health needs as the capabilities, opportunities and motivations to engage in sexual health-related behaviour, both precautions and risks.

A central research objective of EMIS was to identify sexual health needs that are commonly unmet across the population of gay, bisexual, other MSM, and transgender and non-binary people to prioritise those needs for intervention. EMIS asked about needs related to several types of precautionary behaviour and health outcomes. It also asked about some health needs not related to specific behaviours, including experience of stigma and discrimination, stress within their community [1], and internalised homonegativity. Detailed findings for transgender respondents are provided in **Chapter 8**. **Chapter 9** reports key indicators for health promotion needs across the target groups, which are identified in **Chapter 3**. A description of the regional variation in these needs is provided in **Section 6.7**.

6.1 Unmet needs related to all health behaviours

Some health needs are not behaviour-specific but relate to a wide range of behaviour types and outcomes. Essential health provisions for MSM are freedom from stigmatisation and discrimination, in their personal environment as well as in public, and particularly in health care settings, and freedom from internalised homonegativity [2].

6.1.1 Stigma and discrimination

Stigma and discrimination remain significant unmet needs affecting the health and well-being of MSM, transgender and non-binary people. Results specific to transgender respondents are presented in **Chapter 8**. **Figure 6.1** presents the recency of these experiences, highlighting how frequently MSM face stigma, discrimination, and violence in different settings

Social discrimination

Study participants were asked: *"When was the last time you…"* followed by three statements:

- *"…felt excluded from family activities because you have sex with men?"*
- *"…felt that family members have made discriminatory remarks or gossiped about you because you have sex with men?"*
- *"…felt rejected by your friends because you have sex with men?"*

Around one in five respondents (19.5 %) reported ever being excluded from family activities. Around 32.3% felt they were discriminated against by their family, and around one in four felt rejected by friends due to their sexuality (26.4%).

Healthcare-related discrimination

Study participants were asked: *"When was the last time you…"* followed by four statements:

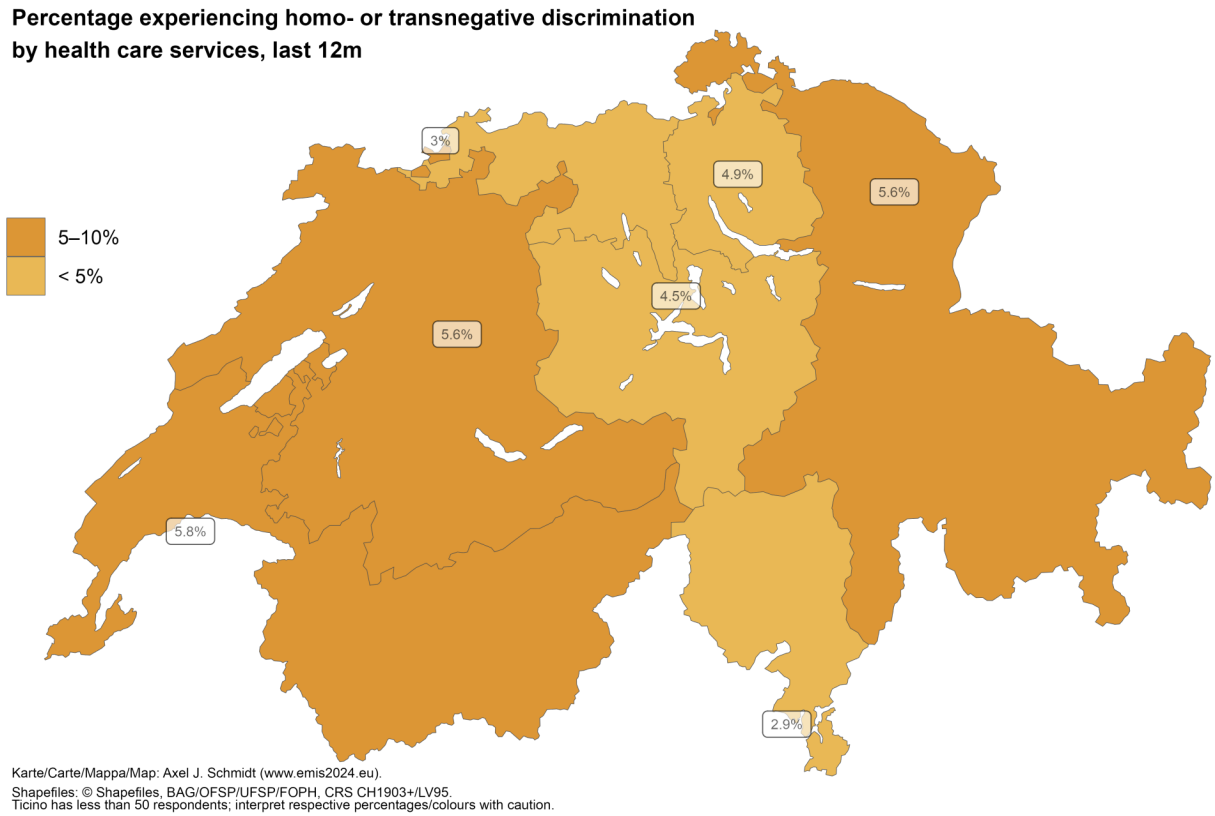
- *"…felt afraid to go to health care services because you worry someone may learn you have sex with men?"*
- *"…avoided going to health care services because you worry someone may learn you have sex with men?"*
- *"…felt that you were not treated well in a health centre because someone knew that you have sex with men?"*
- *"…heard health care providers gossiping about you (talking about you) because you have sex with men?"*

Overall, 19.7 % of respondents were afraid to access healthcare services in their lifetime, and 5.9 % in the last 12 months. Around one in ten respondents (9.6 %) had ever actively avoided healthcare. Around one in

six respondents reported ever having received poor treatment in healthcare settings (15.8 %), and 11 % had ever experienced discrimination in healthcare settings.

Around one in 20 respondents (4.9 %) respondents reported homo- or transnegative by health care services**.** **Map 6.1** illustrates this proportion with minor variation across Switzerland.

Map 6.1 Percentage experiencing homo- or transnegative discrimination by health care services, last 12m (N = 1509)



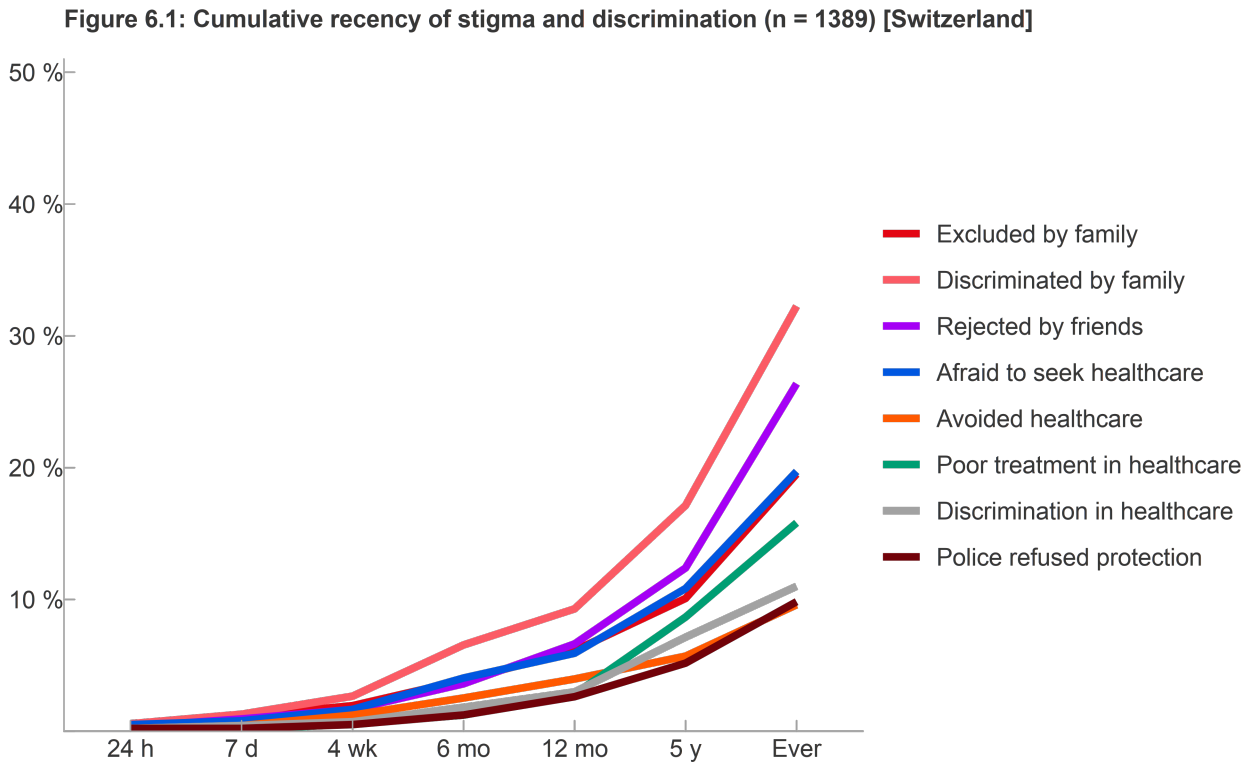
Law enforcement-related discrimination

Study participants were asked: *"When was the last time you…"*

- *"…felt that the police refused to protect you because you have sex with men?"*

Across Switzerland, 9.8 % of respondents reported that the police refused to protect them in their lifetime, while 2.6 % in the last 12 months.

Figure 6.1 Recency curve for experiencing stigma and discrimination



6.1.2 Homonegative abuse: intimidation, insults and violence

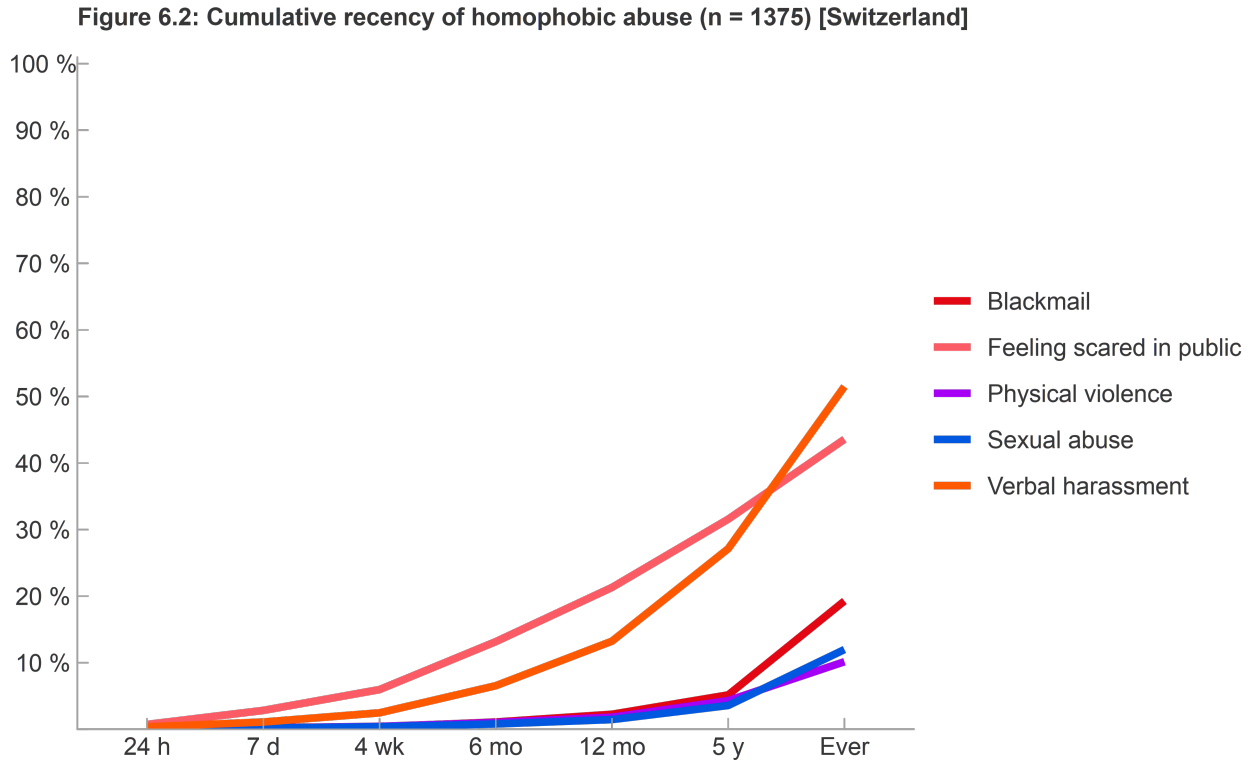
The term *homonegative* is often preferred over *homophobic* because it more accurately captures a broad range of negative attitudes, beliefs, and biases against homosexuality or people perceived as gay, without implying clinical fear or phobia. The word *homophobia* suggests an irrational fear, which can be misleading when referring to systemic prejudice, moral judgement, or cultural stigma.
Homonegativity better reflects the social and ideological dimensions of anti-gay bias, making it more appropriate for academic and research contexts.

We asked about one negative intervention – homonegative abuse. Homonegative abuse undermines all health-related needs. It causes isolation and anxiety as well as physical harm. Study participants were asked: *"When was the last time you…"* followed by three statements:

- *"…were stared at or intimidated because someone knew or presumed you are attracted to men?"*
- *"…had verbal insults directed at you, because someone knew or presumed you are attracted to men?"*
- *"…were punched, hit, kicked, or beaten because someone knew or presumed you are attracted to men?"*

For each statement, respondents were offered a scale to indicate how recently this had occurred. The cumulative percentages for having experienced each event within each time period are shown in **Figure 6.2**.

Figure 6.2 Cumulative recency of stigma and discrimination

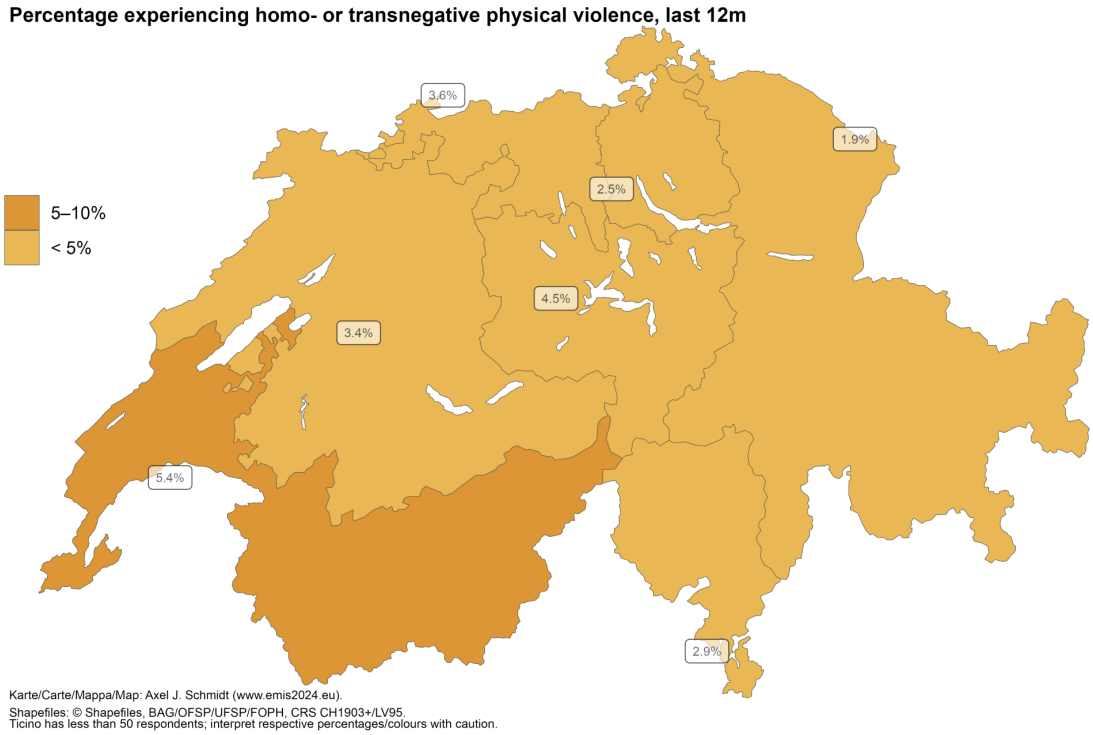


In the last 12 months, around one in 50 respondents (1.8 %) had been physically assaulted— *i.e.,* pushed, shoved, slapped, hit, kicked, choked or otherwise physically hurt (N = 1375, missing n=134). Around one in eight respondents (13.2 %) had been verbally insulted (N = 1375, missing n = 134), and around one in five respondents (21.3 %) had felt scared to be in public places because someone knew or presumed they were attracted to men (N = 1375, missing n =134).

Overall, around one in 100 respondents (1.5 %) reported being sexually assaulted within the last 12 months (N = 1369, missing n =140).

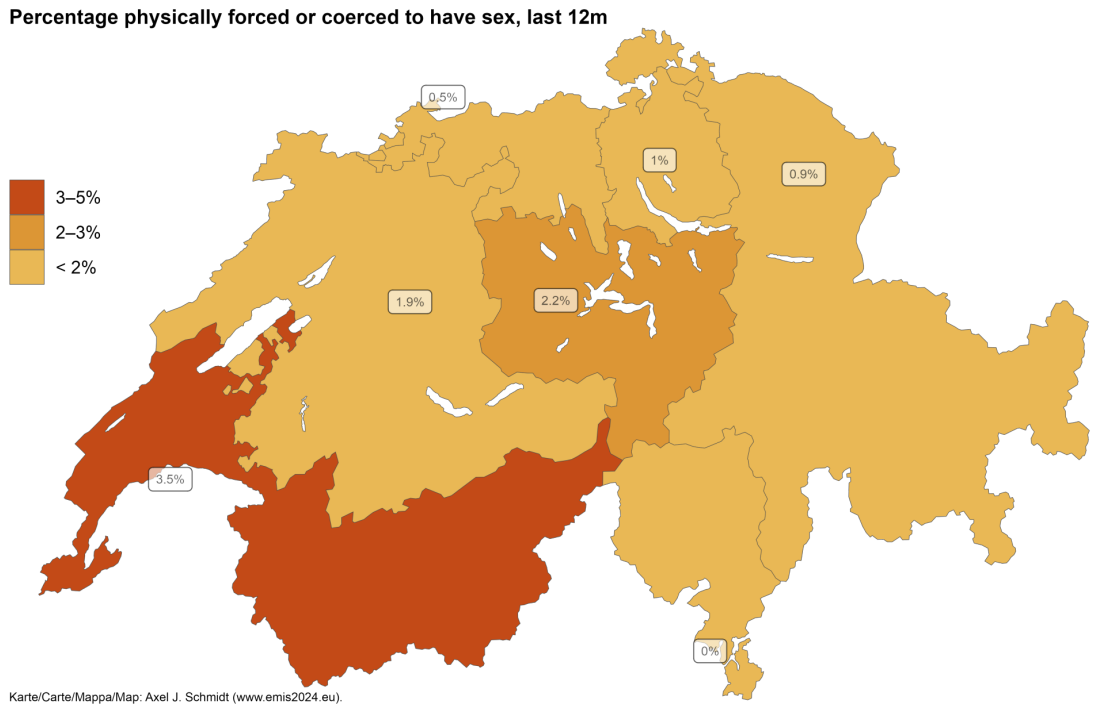
Maps 6.2 and **6.3** show the geographical distribution of experiencing physical violence and of being physically forced or coerced into sex over the past 12 months, with considerable variation across Switzerland—particularly in the French-speaking parts of the country.

Map 6.2 Percentage experiencing homo- or transnegative violence, last 12m (N = 1509)



Karte/Carte/Mappa/Map: Axel J. Schmidt (www.emis2024.eu).
Shapefiles: © Shapefiles, BAG/OFSP/UFSP/FOPH, CRS CH1903+/LV95.
Ticino has less than 50 respondents; interpret respective percentages/colours with caution.

Map 6.3 Percentage physically forced or coerced to have sex, last 12m (N = 1509)



Karte/Carte/Mappa/Map: Axel J. Schmidt (www.emis2024.eu).
Shapefiles: © Shapefiles, BAG/OFSP/UFSP/FOPH, CRS CH1903+/LV95.
Ticino has less than 50 respondents; interpret respective percentages/colours with caution.

6.1.3 Internalised homonegativity

Negative feelings towards one's homosexuality are related to increased sexual risk-taking and less HIV testing, as well as being predictors of anxiety and depression among MSM [3].

To estimate the extent of internalised homonegativity in the sample, we used the short internalised homonegativity scale (SIHS). Study participants were asked: *"Do you disagree or agree with the following statements on a scale of 1 (Strongly Disagree) to 7 (Strongly Agree)? Please do not spend too much time thinking about any one statement (Tick one answer in each row)"*.

They were then presented with the following seven items:

- *I feel comfortable in gay bars/bars that are frequented by gay respondents*
- *Social situations with gay respondents make me feel uncomfortable*
- *I feel comfortable being seen in public with an obviously gay person*
- *I feel comfortable discussing homosexuality in a public situation*
- *I feel comfortable being a homosexual man*
- *Homosexuality is morally acceptable to me*
- *Even if I could change my sexual orientation, I wouldn't*

Responses to each item were provided on a 7-point scale (1 = Strongly Disagree to 7 = Strongly Agree). For scoring, items reflecting positive feelings towards homosexuality were reverse-coded (*e.g.*, a response of '1' was scored as 6, and '7' as 0) while items reflecting negative feelings were scored directly (*e.g.*, '1' was scored as 0, and '7' as 6). This transformation resulted in individual item scores ranging from 0 to 6. A total SIHS score (0 to 42) was calculated by summing the responses across all seven items, and this total was then divided by 7 to yield a mean SIHS score, which ranges from 0 to 6.

Ideally, we would want all scores to be as low as possible (*i.e.*, to be on the extreme left), as this indicates less internalised homonegativity.

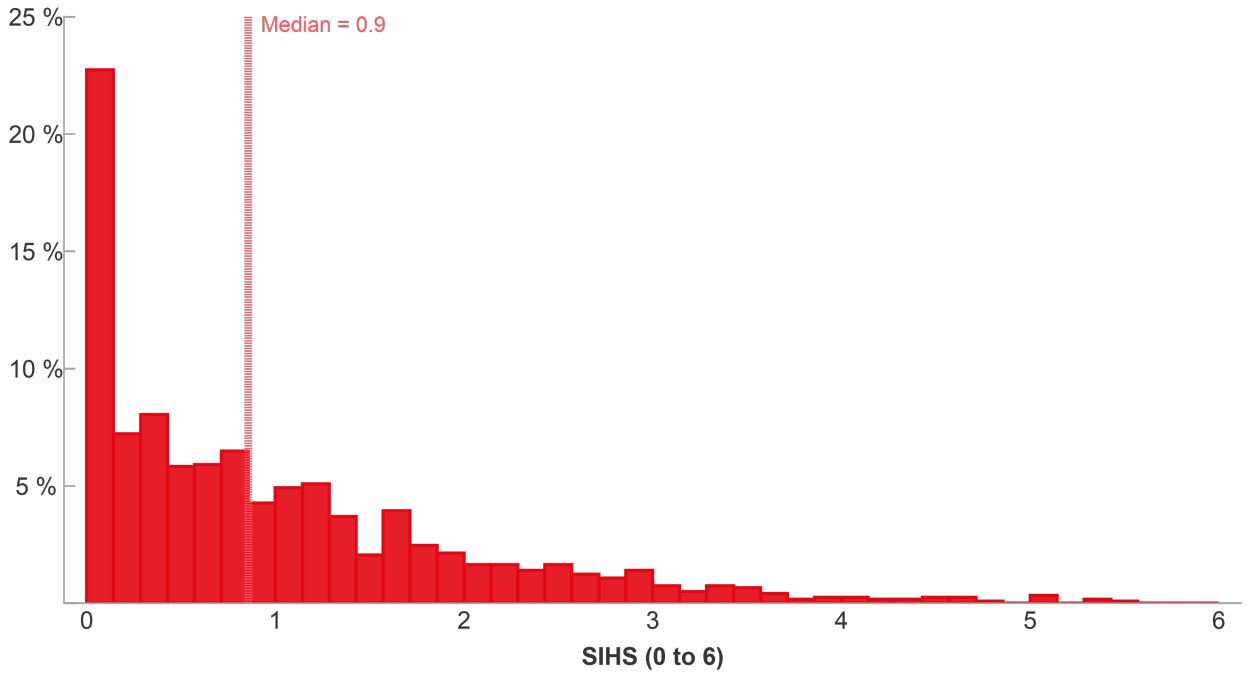
The mean score across Switzerland was 1.1 (median: 0.9). One in six respondents (16.3 %) scored zero, the "best" possible score, and 6.6 % scored above the halfway point on the scale (*i.e.* more than 3).

Internalised homonegativity in a population could be reduced through improving LGB human rights and reducing homonegative social climates [2]. The following figure shows how internalised homonegativity varied across Switzerland.

Figure 6.3 Score (mean) for the SIHS (0 to 6)

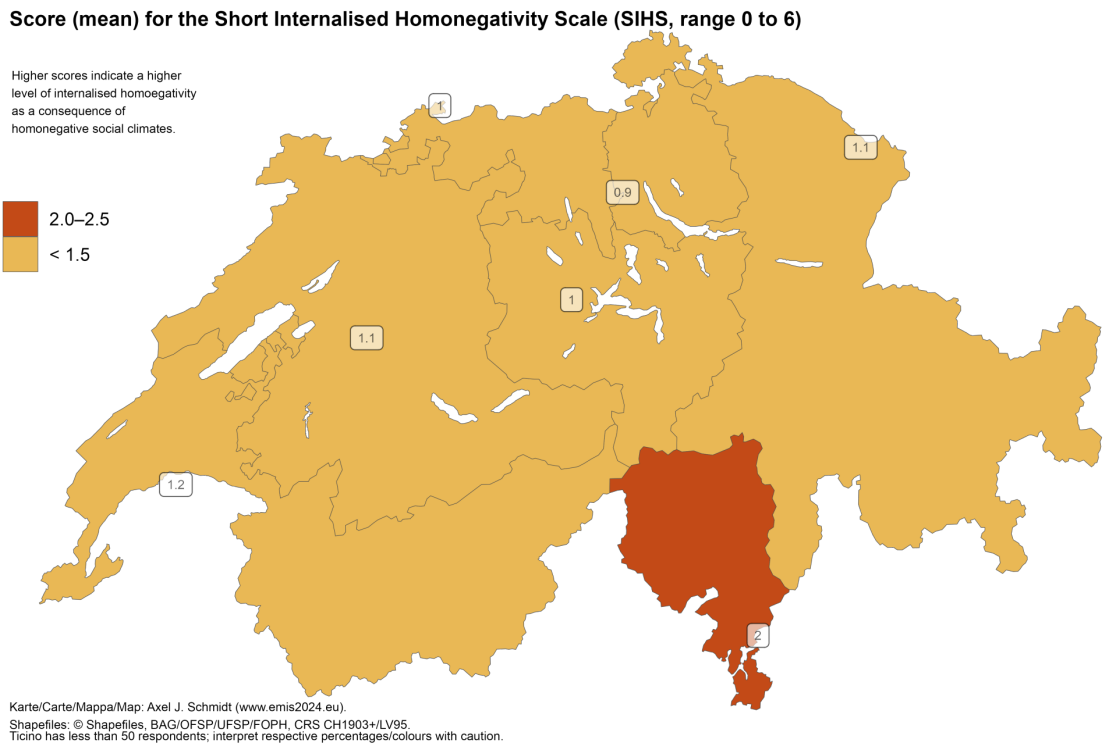
Figure 6.3: Short Internalised Homonegativity Scale (SIHS); (n = 1218) [Switzerland]

Dashed line indicates median value.



Map 6.4 shows how the mean SIHS scores are distributed across Switzerland.

Map 6.4 Short Internalised Homonegativity Scale scores for the whole sample (N = 1218)



6.1.4 Stress within the community

Intra-minority stress theory (or gay Community stress theory), developed by Pachankis *et al.* [1], integrates three theoretical frameworks to explain mental health disparities among gay and bisexual men. These foundational theories are: intra-sex competition theory [4], sexual field theory [5], and theory of precarious manhood [6]. Each describes how men, in general, experience stress due to status hierarchies within the gay community. The theory posits that sexual minority men's reliance on other men for social and sexual fulfilment can generate unique stressors, particularly through masculine, status-based competition. This dynamic may exacerbate stress related to social hierarchies, contributing to mental health challenges within gay and bisexual male communities. The scale included 19 items based on appearance, social status, racial or ethnic marginalisation, competition and comparison, and rejection by other MSM. Responses were rated on a 5-point Likert scale ranging from 1 (*"Strongly Disagree"*) to 5 (*"Strongly Agree"*), with higher scores indicating greater perceived intra-minority stress.

Overall, respondents reported a moderate level of intra-minority stress, with an average score of 3.3 out of 5. Highest stress levels were reported on the sexual scale, with an average of 3.5 out of 5. Social exclusion and competition subscales scores were similar, 3.2 out of 5.

14.3 % of the respondents scored high on overall intra-minority stress, highlighting that nearly one in seven MSM race persistent stress that originated within the mainstream gay community.

6.1.4.1 Stressors related to sex

Study participants were asked: *"Do you disagree or agree with the following statements on a scale of strongly disagree to strongly agree? Please do not spend too much time thinking about any one statement"*.

- *The mainstream gay community values sex over meaningful relationships*
- *It is difficult to maintain a romantic relationship in the mainstream gay community*
- *The mainstream gay community is overly focused on sex*
- *In the mainstream gay community, everyone has sex with each other*
- *The mainstream gay community is overly preoccupied with hookup/dating apps*
- *In the mainstream gay community, there is a lot of risky sex*

Table 6.1 shows the percentages of each statement based on their response.

Table 6.1 Participant' agreement on sex-related stressors within their community

Sex subscale agreement statements	Strongly disagree	Disagree	Neither / not sure	Agree	Strongly agree
	%				
The mainstream gay community values sex over meaningful relationships[a] n = 1355	4.8	12.1	25.6	40.4	17.0
It is difficult to maintain a romantic relationship in the mainstream gay community[b] n = 1356	7.0	17.3	21.0	39.2	15.5
The mainstream gay community is overly focused on sex[c] n = 1356	3.4	9.7	18.7	47.1	21.2
In the mainstream gay community, everyone has sex with each other[d] n = 1355	11.9	23.5	24.2	31.6	8.9
The mainstream gay community is overly preoccupied with hookup/dating apps[e] n = 1356	2.7	8.0	21.2	48.6	19.5
In the mainstream gay community, there is a lot of risky sex[f] n = 1356	2.4	9.5	18.6	46.4	23.1

[a] Missing n = 41; [b] Missing n = 40; [c] Missing n = 40; [d] Missing n = 41; [e] Missing n = 40; [f] Missing n = 40

69.5 % of respondents felt that the mainstream gay community involves a great deal of risky sexual behaviour, and 68.3 % felt it is overly focused on sex. A total of 30.8 % scored high on the sexual expectations subscale, with a mean score of 3.5.

6.1.4.2 Stressors related to competition

Study participants were asked: *"Do you disagree or agree with the following statements on a scale of strongly disagree to strongly agree? Please do not spend too much time thinking about any one statement"*.

- *The mainstream gay community is overly gossipy*
- *The mainstream gay community has a culture of competition and jealousy*
- *The mainstream gay community is overly cliquey*
- *In the mainstream gay community, there is a lot of mistrust among friends*
- *The mainstream gay community is overly judgmental*
- *The mainstream gay community is overly materialistic*

Table 6.2 shows the percentages of each statement based on their response.

Table 6.2 Participants' agreement on competition-related stressors within their community

Competition subscale agreement statements	Strongly disagree	Disagree	Neither / not sure	Agree	Strongly agree
	%				
The mainstream gay community is overly gossipy[a] n = 1372	4.2	10.9	35.7	36.1	13.1
The mainstream gay community has a culture of competition and jealousy[b] n = 1372	4.9	15.5	31.8	36.0	11.8
The mainstream gay community is overly cliquey[c] n = 1371	6.2	21.3	37.3	26.8	8.4
In the mainstream gay community, there is a lot of mistrust among friends[d] n = 1374	13.2	31.5	36.5	14.4	4.4
The mainstream gay community is overly judgmental[e] n = 1377	5.1	17.9	25.3	38.6	13.0
The mainstream gay community is overly materialistic[f] n = 1373	6.3	17.5	35.2	31.1	9.9

[a] Missing n = 24; [b] Missing n = 24; [c] Missing n = 25; [d] Missing n = 22; [e] Missing n = 19; [f] Missing n = 23

Over half of the respondents perceived the mainstream gay community as overly gossipy (49.2 %) and judgemental (51.6 %), while about 47.8 % feel that there is a culture of competition and jealousy and that the community is overly cliquey (35.2 %). However, around 18.8 % of the respondents reported trust within their friends and social circle. Of all respondents, 17 % reported high competition-related stress, with a mean score of 3.2.

6.1.4.3 Stressors related to exclusion

Study participants were asked: *"Do you disagree or agree with the following statements on a scale of strongly disagree to strongly agree? Please do not spend too much time thinking about any one statement"*.

- *The mainstream gay community is racist*
- *The mainstream gay community sexually objectifies men of colour*
- *The mainstream gay community discriminates against its members who have HIV/AIDS*
- *The mainstream gay community overly values physically fit bodies*
- *The mainstream gay community overly values penis size*
- *The mainstream gay community overly values being masculine*
- *The mainstream gay community sees older men as less desirable*

Table 6.3 shows the percentages of each statement based on their response.

Table 6.3 Participant' agreement on exclusion within their community

Exclusion subscale agreement statements	Strongly disagree	Disa-gree	Neither / not sure	Agree	Strongly agree
	%				
The mainstream gay community is racist[a] n = 1384	21.0	32.7	28.0	15.1	3.2
The mainstream gay community sexually objectifies men of colour[b] n = 1384	18.6	24.5	28.7	24.2	4.0
The mainstream gay community discriminates against its members who have HIV/AIDS[c] n = 1385	11.9	26.7	33.6	23.5	4.3
The mainstream gay community overly values physically fit bodies[d] n = 1386	3.0	6.1	13.1	46.0	31.8
The mainstream gay community overly values penis size[e] n = 1386	2.5	5.9	18.7	46.5	26.4
The mainstream gay community overly values being masculine[f] n = 1382	4.8	16.1	34.7	32.5	11.9
The mainstream gay community sees older men as less desirable[g]	4.0	11.8	17.5	40.5	26.1

Exclusion subscale agreement statements	Strongly disagree	Disa-gree	Neither / not sure	Agree	Strongly agree
	%				
n = 1385					

[a] Missing n = 12; [b] Missing n = 12; [c] Missing n = 11; [d] Missing n = 10; [e] Missing n = 10; [f] Missing n = 14; [g] Missing n = 11

A clear majority of the respondents perceive physical ideals agreed that the community overly values physically fit bodies (77.8 %) and penis size (72.9 %). While around two out of five feel there is pressure to conform to masculinity standards (44.4 %). Ageism is prevalent, with around three out of five agreeing older men are seen as less desirable (66.6 %).

Ultimately, 16.5 % reported high exclusion-related stress, with a mean score of 3.3.

6.2 Unmet needs for Safer Sex

For respondents to have Safer Sex, they need opportunities, capabilities and the motivation to do so. We measured knowledge (motivation), condom access (opportunities) and sexual self-efficacy (capabilities) to provide an overview of unmet safer sex needs.

6.2.1 Low self-efficacy: safe as I want to be and easy to say 'No'

Study participants were asked whether they disagreed or agreed with the following two statements.

- *The sex I have is always as safe as I want it to be*
- *I find it easy to say "no" to sex I don't want*

In response to the statements, around one in seven of the respondents indicated that they feel less in control over safer sex (15.3 %) and unwanted sexual experiences (15.1 %) as they want it to be, indicating a need for greater sexual self-efficacy. **Table 6.4** shows the percentages selecting for each response.

Table 6.4 Self-efficacy measures

Statements on sex life satisfaction	The sex i have is always as safe as i want it to be N = 1507	i find it easy to say 'no' to sex i don't want N = 1506
Strongly agree	46.4	47.1
Agree	38.2	37.8
Neither / not sure	5.8	6.8
Disagree	7.0	6.2
Strongly disagree	2.5	2.2
Total	**100**	**100**

6.2.2 Low HIV and STI transmission knowledge

Respondents were told: *"The following statements are all TRUE. Did you know this already?"* and then they were offered the following statements:

- *HIV cannot be passed during kissing, including deep kissing, because saliva does not transmit HIV*
- *You can pick up HIV through your penis while being 'active' in anal or vaginal sex (fucking) without a condom, even if you don't ejaculate*
- *You can pick up HIV through your rectum/vagina while being "passive" during sex (being fucked)*
- *Most sexually transmitted infections can be passed on more easily than HIV*
- *Because they sometimes have no symptoms, people can have sexually transmitted infections without knowing it*
- *The correct use of condoms throughout intercourse reduces the likelihood of picking up and passing on STIs (including HIV)*

Table 6.5 shows the percentages selecting each response. The last column on the right (*"Did not Already Knew"*) is the overall sum of the respondents who did not already know the statement was true.

Table 6.5 HIV and STI transmission knowledge

HIV and STI transmission knowledge statements	Already knew	Wasn't sure	Didn't know	Don't understand	Do not believe	Did not already knew
	% of all respondents					
HIV cannot be passed during kissing, including deep kissing, because saliva does not transmit HIV[a] n = 1507	94.3	4.2	1.0	0.1	0.4	5.7
You can pick up HIV through your penis while being 'active' in anal or vaginal sex (fucking) without a condom [even if you don't ejaculate][b] n = 1450	92.0	5.2	1.8	0.2	0.8	7.7
You can pick up HIV through your rectum/vagina while being 'passive' during sex (being fucked)[c] n = 1476	96.0	2.3	1.4		0.3	3.9
Most sexually transmitted infections can be passed on more easily than HIV[d] n = 1503	80.5	10.4	8.1	0.7	0.3	19.4
Because they sometimes have no symptoms, people can have sexually transmitted infections without knowing it[e] n = 1501	89.5	5.5	4.1	0.6	0.2	10.4
The correct use of condoms throughout intercourse reduces the likelihood of picking up and passing on STIs (including HIV) n = 1497	96.3	2.2	0.6	0.4	0.5	3.6

[a] Missing n = 2; [b] Missing n = 7; [c] Missing n = 7; [d] Missing n = 6; [e] Missing n = 8; [f] Missing n = 12

Basic knowledge about HIV/STI transmission was generally high. However, there is still a lack of knowledge on the HIV risk of insertive intercourse, the existence of asymptomatic infections and the differences in transmissibility of other STIs compared with HIV.

Less than 0.5 % of respondents (0.5 %) did not already know any of these six facts, 0.3 % did not know five of the six, 1.1 % did not know four, 3 % did not know three, 8.2 % did not know two, and 14.2 % did not know one of the six. The remaining 72.8 % indicated they already knew all six facts. Community-based education can address the lack of knowledge in certain areas.

6.3 Unmet needs for safer drug use: drug use concern

Respondents who indicated that they had taken any illicit drug in the last 12 months were asked whether they disagreed or agreed with the following statement: *"I worry about my recreational drug use"*. While current good practice in drug use measurement recommends avoiding the term 'recreational' (as it is imprecise), we have retained it here as the question is identical to that asked in EMIS-2010 and EMIS-2017.

Table 6.6 Concern about recreational drug use among the whole sample, and among respondents taking drugs in the last year

Worries related to recreational drug use	All respondents N = 1509	Respondents who used drugs in the last 12m N = 860
	%	%
Strongly disagree	31.2	54.8
Disagree	8.7	15.2
Neither / not sure	2.9	5.1
Agree	3.7	6.5
Strongly agree	1.0	1.7
I don't take drugs	9.5	16.6
[Not asked as indicated no drug use last 12 months]	43.0	-
Total	**100**	**100**

Missing n = 0

Among participants who used at least one illicit drug in the last 12 months, 8.3 % agreed that they worry about their recreational drug use, including 1.7 % who *strongly agreed*. Of the respondents who earlier in the survey had indicated that they had used at least one illicit drug in the last 12 months, 16.6 % selected *"I don't take drugs"* in response to the question about concern about drug use. This was presumably because they had rarely used drugs during the last year or because they had discontinued their use in the past year.

Overall, the percentage of respondents who agreed that they worry about their drug use was 4.7 %.

6.4 Unmet needs for PrEP use (Pre-Exposure Prophylaxis)

HIV Pre-Exposure Prophylaxis (PrEP) is an HIV prevention tactic of taking anti-HIV drugs before and after exposure to prevent HIV infection. In order to take PrEP, respondents need the opportunity to use it, the motivation to do so and the capability both to access PrEP and to take it effectively.

6.4.1 Unaware of PrEP

Study participants were asked: *"Have you heard of PrEP?"* 96 % indicated *"Yes"* and 4 % responded *"No"*. Therefore, almost all (85.8 %) of all respondents have basic PrEP awareness.

6.4.2 Low PrEP knowledge

Study participants were asked: *"The following statements are all TRUE. Did you know this already?"* and were offered the following statements:

- *Pre-Exposure prophylaxis (PrEP) involves someone who does not have HIV taking pills before as well as after sex to prevent them getting HIV*
- *PrEP can be taken as a single daily pill if someone does not know in advance when they will have sex*
- *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*

Table 6.7 below shows the percentages indicating each response. The last column on the right (*"Did not Already Knew"*) is the overall sum of the respondents who did not already know the statement was true. (Following these items, respondents were told, *"Please note: taking PrEP just before and after sex has been shown to be protective in anal but not vaginal intercourse."*)

Table 6.7 Pre-Exposure Prophylaxis (PrEP) knowledge

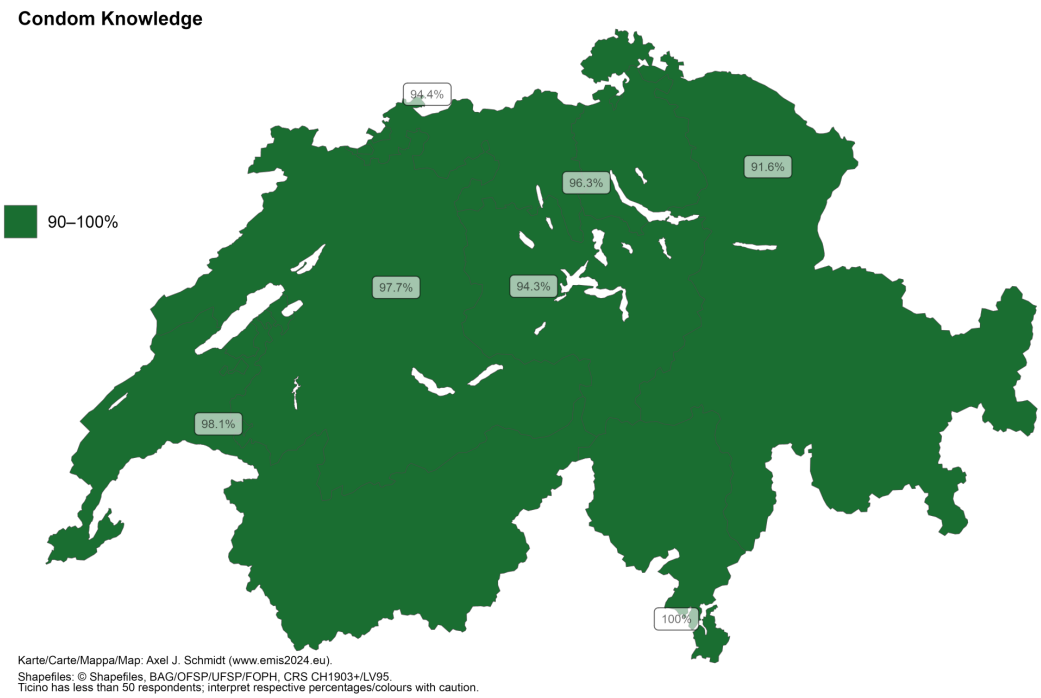
PrEP knowledge statements	Already knew	Wasn't sure	Didn't know	Don't under-stand	Do not believe	Did not know al-ready
	% of all respondents					
Pre-Exposure prophylaxis (PrEP) involves someone who does not have HIV taking pills before as well as after sex to prevent them getting HIV[a] n = 1350	83.6	8.9	6.3	0.1	1.1	14.6
PrEP can be taken as a single daily pill if someone does not know in advance when they will have sex[b] n = 1342	80.8	8.3	10.5	0.1	0.3	17.1
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[c] n = 1344	59.8	15.3	23.9	0.2	0.8	35.8
Gender-affirming hormone therapy with testosterone does not affect PrEP efficacy in any way[d] n = 48	29.2	31.2	39.6			2.3
If you are on oestrogen as part of your gender-affirming hor-mones, PrEP is effective only if taken in the modality of a single daily pill[e] n = 14			100.0			0.9

[a] Missing n = 1; [b] Missing n = 9; [c] Missing n = 7; [d] Missing n = 0; [e] Missing n = 0

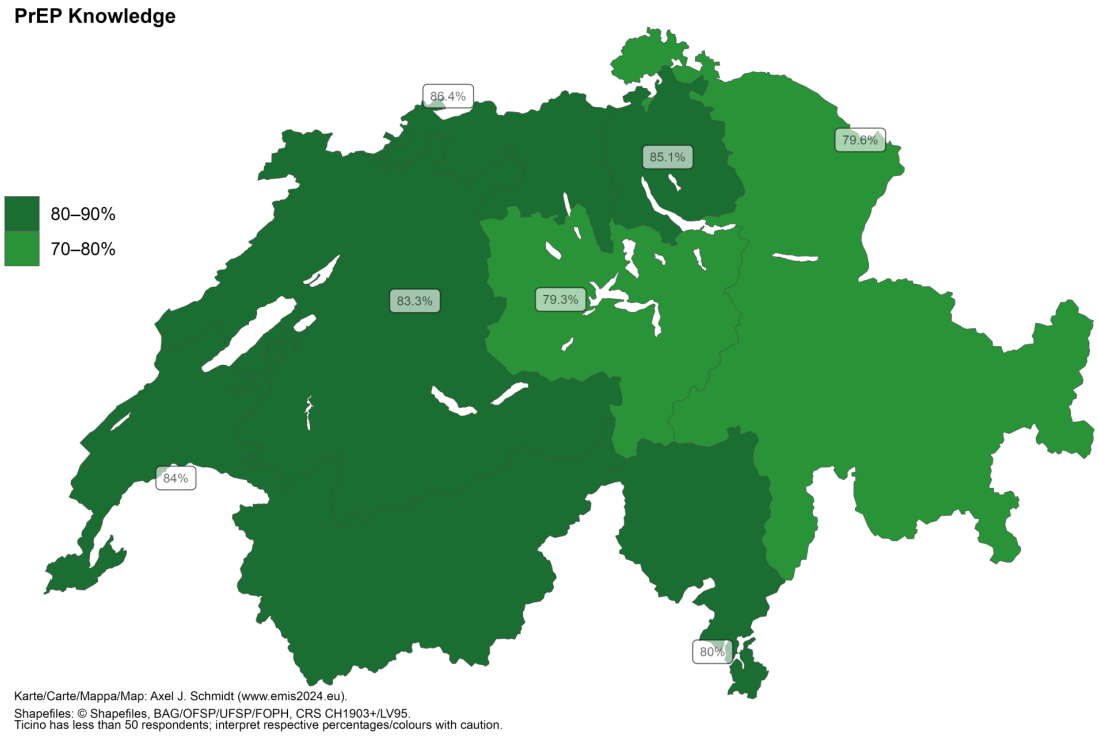
There was a high proportion of respondents in need of knowledge about PrEP on-demand dosing options (39.2 %). Notably, 63 % indicated they already knew all six facts. 10.1 % did not already know any of these three facts, 10 % did not know two and 16.9 % did not know one.

As condom knowledge has become universal after 40 years of condomisation campaigns targeting both the general population and MSM, it can serve as a benchmark for other types of sexual health knowledge (**Map 6.5**). Compared to EMIS-2017 results, across Switzerland, PrEP knowledge has substantially improved (**Map 6.6**).

Map 6.5 Percentage Condom knowledge (N = 1497)



Map 6.6 Percentage PrEP knowledge (N = 1350)



PrEP knowledge varied across Switzerland; this unmet need can be addressed with community-based education.

6.4.3 Trusting in U=U or PrEP surfing

Study participants received an introductory text, about the definition of **Safer Sex**: *Over the past decade, the definition of Safer Sex has experienced significant changes. Previously, Safer Sex primarily revolved around the consistent use of condoms during intercourse. However, our understanding has evolved, and we now recognise that individuals with an undetectable HIV viral load cannot transmit HIV through sexual contact (known as "U=U"), and the use of PrEP before and after sex can effectively prevent HIV infection.* Participants then specified their most frequent HIV prevention strategy (*information about the use of HIV prevention strategies can be found in* **Section 5.3.4** *and* **Table 5.7**). Based on their responses, participants were then asked to rate, from *"1 – not at all"* to *"5 – completely"*, the extent to which they…:

- *"…trust U=U (you resp. your partner has an undetectable viral load) as a way to prevent HIV transmission?"*
- *"….trust PrEP surfing (your partner uses PrEP) as an HIV prevention strategy?"*

A total of 134 respondents (9 %) reported relying on U=U as their most frequent HIV-prevention strategy. Of these,28.9 % indicated that they completely trust it, while 15.8 % reported *"a little"* or *"not at all"*.

In contrast, a total of 57 respondents (3.8 %) reported relying on 'PrEP surfing'; among them 24.5 % expressed complete trust, and 10.2 % reported trusting it *"a little"* or *"not at all"*.

Table 6.8 Trust in U=U and PrEP surfing

Reported degree/Extent of trust	U=U (you resp. your partner has an undetectable viral load) as a way to prevent HIV transmission* N = 38	PrEP surfing (your partner uses PrEP) as an HIV prevention strategy** N = 49
	%	%
None at all	-	-
A little	15.8	10.2
A moderate amount	13.2	26.5
A lot	42.1	38.8
Completely	28.9	24.5
Total	**100**	**100**

* Missing n = 0; ** Missing n = 0

6.5 Unmet needs for HIV testing and treatment

Effective HIV treatment functions as the primary HIV prevention. Since HIV testing is the essential gateway for people with HIV, facilitating HIV testing is now a major goal of most HIV prevention programmes. To test for HIV, respondents need an opportunity to test, the motivation to seek or accept an offer of a test, and the capability of doing so.

6.5.1 Low HIV test/treatment knowledge

Respondents were told: *"The following statements are all TRUE. Did you know this already?"* and were offered each of the statements:

- *AIDS is caused by a virus called HIV*
- *You cannot be confident about whether someone has HIV or not from their appearance*
- *There is a medical test that can show whether or not you have HIV*
- *If someone becomes infected with HIV it may take several weeks before it can be detected in a test*
- *There is currently no cure for HIV infection (aside from a handful of people who appear to have been cured in the course of treatment for a specific rare type of cancer)*
- *HIV infection can be controlled with medicines so that its impact on health is much less*
- *A person with HIV who is on effective treatment (called "undetectable viral load") cannot pass their virus to someone else during sex*

Table 6.9 below shows the percentages selecting each response. The column on the right adds together all those who did not already know the statement was true.

Table 6.9 HIV testing and treatment knowledge

HIV testing and treatment knowledge statements	Already knew	Wasn't sure	Didn't know	Don't understand	Do not believe	Did not know already
	% of all respondents					
AIDS is caused by a virus called HIV[a] n = 1508	98.2	1.1	0.1		0.6	1.8
You cannot be confident about whether someone has HIV or not from their appearance[b] n = 1504	96.7	1.1	0.3	0.1	1.8	3.2
There is a medical test that can show whether or not you have HIV[c] n = 1500	99.4	0.1	0.1	0.1	0.4	0.6
If someone becomes infected with HIV it may take several weeks before it can be detected in a test[d] n = 1503	90.8	6.3	2.0	0.1	0.9	9.2
There is currently no cure for HIV infection (aside from a handful of people who appear to have been cured in the course of treatment for a specific rare type of cancer)[e] n = 1508	87.9	8.4	2.1	0.4	1.3	12.1
HIV infection can be controlled with medicines so that its impact on health is much less[f] n = 1501	97.0	2.5	0.1		0.3	3.0
A person with HIV who is on effective treatment (called 'undetectable viral load') cannot pass their virus to someone else during sex[g] n = 1503	86.4	8.6	3.4	0.1	1.4	13.5

[a] Missing n = 1; [b] Missing n = 5; [c] Missing n = 9; [d] Missing n = 6; [e] Missing n = 1; [f] Missing n = 8; [g] Missing n = 6

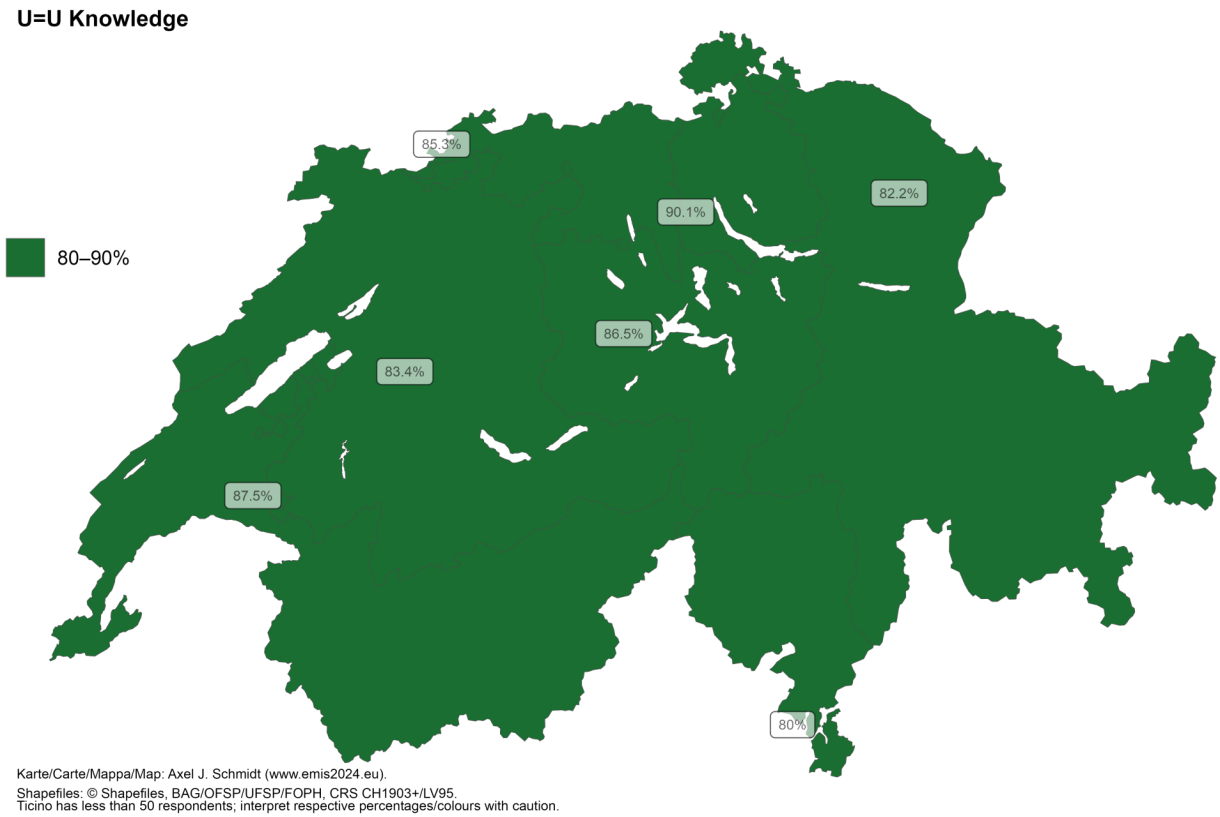
Around three out of four *already knew all seven test and treat facts* (73.4 %). 0.1 % did not know any of the test and treat facts. 0.1 % did not know six of them, 0.3 % did not know five, 0.9 % did not know four, 2.6 % did not know three, 6.8 % did not know two and 16 % did not know one of the seven facts.

In general, the mean number of facts about HIV testing and treatment not already known was 1.6.

Regional variation of this figure is presented in **Section 6.7**, at the end of this chapter. Knowledge of HIV testing and treatment was generally high, except for the fact that a person with HIV who is on effective treatment (called 'undetectable viral load') cannot pass their virus to someone else during sex— with a sum of 13.5 % who did not know.

The first country to publicly talk about U=U was Switzerland in 2008 (then called the "Swiss statement") [7]. In 2024, U=U knowledge was high with only minor regional variation across Switzerland (**Map 6.7**).

Map 6.7 U=U knowledge (N = 1503)



6.5.2 Not knowing where to get an HIV test

Respondents who had never tested for HIV (9.4 % of all respondents, see **Section 7.5.1**) were asked: *"Do you know where you could get an HIV test?"*. Among those, around one in 17 respondents (who had never been tested) *did not know* where to get an HIV test (5.6 %), and 21.1 % were *"unsure"*.

The need to know where to test for HIV was unmet for 5.6 % of respondents (who had never tested). Increasing community education and promoting available services can help overcome the barrier of not knowing where to get an HIV test.

Overall, 9.8 % of respondents indicated they had been diagnosed with HIV (see **Section 4.2.1**). Of these respondents, 8.2 % had never taken antiretroviral treatment and of the 89.7 % who had ever taken ART, 0 % were not currently taking it (see **Section 5.1.1** on ART). The remaining 2.1 % of respondents with diagnosed HIV did not know whether they had ever taken ART, indicating a small but serious gap in treatment knowledge.

6.5.3 HIV testing preferences

Study participants were asked: *"What would be your first choice for HIV testing, if you could choose freely?"* and given the options:

- General Practitioner/family doctor

- A doctor in private practice
- At a hospital, clinic or institute as an out-patient
- At a hospital as an in-patient
- At a community health service or drop-in centre (not in a hospital or clinic)
- At a blood bank, while donating blood
- I would like to use a self-sampling kit (taking my own sample, then sent it away for analysis)
- I would like to use a self-testing kit (to find out the result on the spot)
- In a bar/pub, club or sauna
- Mobile testing unit
- Elsewhere

They were then presented with the follow-up question: *"What are the main reasons for your previous choice regarding HIV testing? (Tick as many as apply)"*, to which they could respond with:

- It is LGBT friendly
- It is affordable
- It is non-judgmental
- It is easy to reach
- It is anonymous
- I receive personal advice
- It is possible to communicate in my native language
- It is led by medical professionals with expertise on sexual health
- It is led by peers with expertise on sexual health
- It offers additional services to HIV testing
- None of the above

Respondents most frequently preferred to be tested for HIV at a community health service or drop-in centre (not in a hospital or clinic) as their first choice (47 %), followed by General Practitioner / family doctor (19.1 %)

Table 6.10 HIV testing preferences

Reason for their choice	A doctor in private practise	At a blood bank, while donating blood	At a community health service or drop-in (not in a hospital or clinic)	At a gender-affirming care service	At a hospital as an in-patient	At a hospital or clinic as an out-patient, or an institute	Elsewhere	General practitioner / family doctor	I would like to use a self-sampling kit (I took my own sample then sent it away to be analysed)	i would like to use a self-testing kit (I found out the result on the spot)	In a bar/pub/club	Mobile testing unit
It is LGBT friendly	10.0	0.2	68.4	2.7	0.2	3.5	0.2	8.7	0.8	3.2	1.2	1.1
It offers additional services to HIV testing	9.3	0.9	61.9	2.1	0.0	5.2	0.9	15.0	0.7	2.3	1.1	0.7
None of the above	9.4	0.0	31.2	0.0	0.0	0.0	0.0	21.9	9.4	21.9	6.2	0.0
It is affordable	5.3	0.8	59.5	2.1	0.0	3.2	0.5	8.9	1.8	14.2	2.6	1.1
It is non-judgmental	9.5	1.0	56.0	2.2	0.0	5.2	0.4	17.5	1.0	4.9	1.7	0.6
It is easy to reach	5.6	1.4	46.9	1.3	0.4	5.8	0.7	19.9	2.9	11.8	2.0	1.3
It is anonymous	6.3	0.6	49.8	1.8	0.3	4.8	1.2	4.8	4.8	21.0	2.4	2.1
I receive personal advice	11.5	0.6	57.8	2.0	0.0	5.9	0.4	19.1	0.2	1.0	1.2	0.4
It is possible to communicate in my native language	8.8	1.0	51.3	1.0	0.0	7.3	1.0	23.8	1.6	2.1	1.6	0.5
It is led by medical professionals with expertise on sexual health	12.7	0.6	64.5	2.0	0.0	6.5	0.2	9.3	0.6	2.2	0.8	0.6
It is led by peers with expertise on sexual health	5.7	0.0	80.2	2.8	0.0	1.6	0.8	4.0	0.4	1.6	1.6	1.2

The most frequently reported reasons for testing location preferences were:

- *It is non-judgmental* (47.4 %)
- *It is LGBT friendly* (43.6 %)
- *It offers additional services to HIV testing* (37.2 %)
- *It is easy to reach* (36.6 %)
- *I receive personal advice* (33.9 %)

6.6 Unmet needs for viral hepatitis, HPV, and mpox vaccination

Effective vaccines exist for both hepatitis A and B. In order to benefit from them, respondents need an opportunity to be vaccinated, the capability to be vaccinated and the motivation to seek or accept vaccination.

6.6.1 Hepatitis A and B, HPV, and mpox knowledge

Respondents were told: *"The following statements are all TRUE. Did you know this already?"* and were offered the statements:

- 'Hepatitis' means inflammation of the liver
- Hepatitis is often caused by hepatitis viruses, named after the letters of the alphabet
- Vaccines exist for both hepatitis A and hepatitis B
- Doctors recommend men-who-have-sex-with-men are vaccinated against both hepatitis A and hepatitis B viruses

Table 6.11a shows the percentages giving each response. The last column on the right (*"Overall of Did not Already Knew"*) is the sum of the respondents who did not already know the statement was true.

Table 6.11a Hepatitis knowledge

Viral Hepatitis knowledge statements	Already knew	Wasn't sure	Didn't know	Don't understand	Do not believe	Did not know already
	% of all respondents					
'Hepatitis' means inflammation of the liver[a] n = 1509	70.7	15.6	13.3	0.1	0.2	29.3
Hepatitis is often caused by hepatitis viruses, named after the letters of the alphabet[b] n = 1502	87.0	7.0	5.7	0.3	0.1	13.0
Vaccines exist for both hepatitis A and hepatitis B[c] n = 1504	90.6	7.4	1.7	0.1	0.3	9.4
Doctors recommend men-who-have-sex-with-men are vaccinated against both hepatitis A and hepatitis B viruses[d] n = 1419	75.8	12.5	11.1	0.2	0.4	22.7

[a] Missing n = 0; [b] Missing n = 7; [c] Missing n = 5; [d] Missing n = 4

Overall, 1.7 % of respondents did not know any of the four Hepatitis facts, 6.2 % did not know three, 11.3 % did not know two and 0 % did not know one of the four The remaining 0 % already knew all four hepatitis facts. The fact most commonly unknown was that *'Hepatitis' means inflammation of the liver*; a need which is unmet in 29.3 % of respondents. The mean number of facts not known about hepatitis was just over 1.7.

Human Papilloma Virus (HPV) knowledge

Respondents were told: *"The following statements are all TRUE. Did you know this already?"* and were offered the statements:

- Human Papilloma Virus (HPV) causes anal and genital warts
- Human Papilloma Virus (HPV) causes some types of cancer
- Vaccines exist for Human Papilloma Virus (HPV)

Table 6.11b shows the percentages giving each response. The last column on the right (*"Overall of Did not Already Knew"*) is the sum of the respondents who did not already know the statement was true.

Table 6.11b HPV knowledge

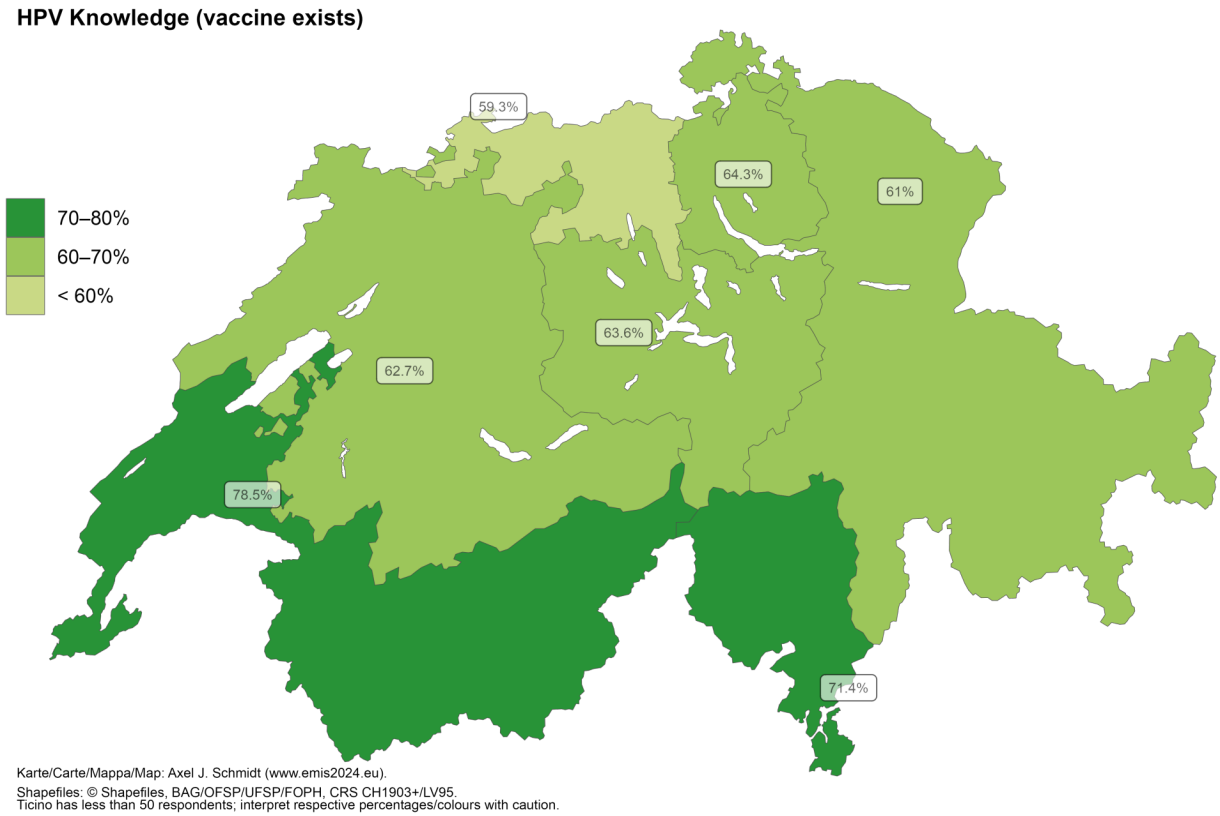
HPV knowledge statements	Already knew	Wasn't sure	Didn't know	Don't understand	Do not believe	Did not know already
	% of all respondents					
Human Papilloma Virus (HPV) causes anal and genital warts* n = 1507	56.9	12.9	29.0	0.8	0.3	43.0
Human Papilloma Virus (HPV) causes some types of cancer n = 1498	61.1	10.5	27.6	0.5	0.3	38.6
Vaccines exist for Human Papilloma Virus (HPV) n = 1496	66.0	9.7	23.4	0.3	0.7	33.7

* Missing n = 2; ** Missing n = 11; *** Missing n = 13

Overall, 23.9 % of respondents did not know any of the three HPV facts, 12.3 % did not know two, 18.4 % did not know one. The remaining 45.4 % already knew all three HPV facts. The fact most commonly unknown was that *Human Papilloma Virus (HPV) causes anal and genital warts*; a need which is unmet in 43 % of respondents. The mean number of facts not known about HPV was just over 2.1.

Map 6.8 illustrates awareness of the HPV vaccine, showing considerable variation across Switzerland.

Map 6.8 HPV knowledge (N = 824)



Mpox knowledge

Respondents were told: *"The following statements are all TRUE. Did you know this already?"* and were offered the statements:

- Since the novel outbreak in 2022, mpox has predominantly affected men who have sex with men
- Mpox is mainly transmitted during sex or close physical contact
- There is a vaccine against mpox that significantly reduces the risk of contracting the disease

Table 6.11c shows the percentages giving each response. The last column on the right (*"Overall of Did not Already Knew"*) is the sum of the respondents who did not already know the statement was true.

Table 6.11c Mpox knowledge

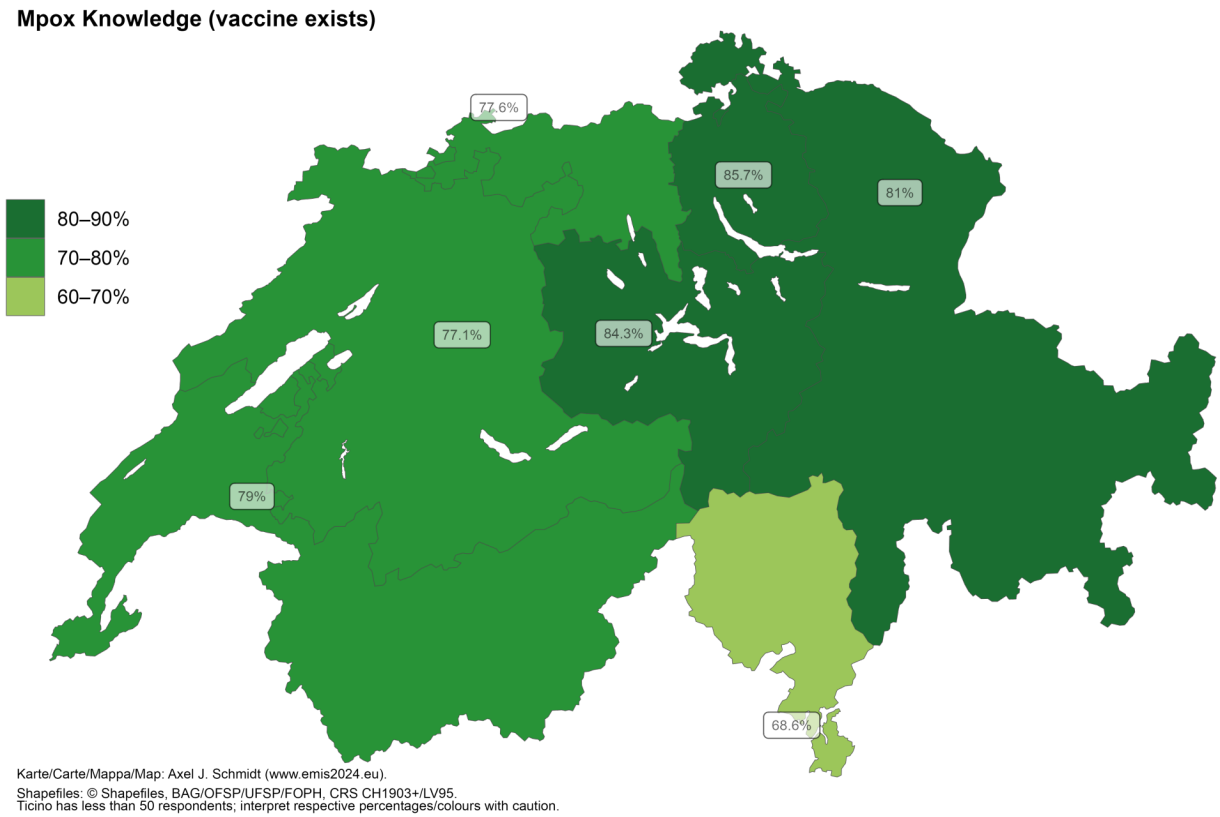
Mpox knowledge statements	Already knew	Wasn't sure	Didn't know	Don't understand	Do not believe	Did not know already
	% of all respondents					
Since the novel outbreak in 2022, `monkeypox´ (mpox) has predominantly affected men who have sex with men[a] n = 1394	83.8	6.7	8.7	0.2	0.6	15.0
Since the novel outbreak in 2022, `monkeypox´ (mpox) has predominantly affected men who have sex with men and gay people[b] n = 1478	83.1	6.8	9.3	0.2	0.6	1.6
Mpox is mainly transmitted during sex or close physical contact[c] n = 1499	82.7	9.0	8.1	0.1	0.1	17.2
There is a vaccine against mpox that significantly reduces the risk of contracting the disease[d] n = 1497	80.8	7.6	11.2	0.1	0.3	19.1

[a] Missing n = 2; [b] Missing n = 2; [c] Missing n = 10; [d] Missing n = 12

Overall, 9.7 % of respondents did not know any of the three mpox facts, 5.2 % did not know two, 11.7 % did not know one. The remaining 73.5 % already knew all three mpox facts. The fact most commonly unknown was that *There is a vaccine against mpox that significantly reduces the risk of contracting the disease*; a need which is unmet in 19.1 % of respondents. The mean number of facts not known about mpox was just over 1.9.

Map 6.9 illustrates awareness of the mpox vaccine, showing considerable variation across Switzerland.

Map 6.9 Mpox knowledge (N = 400)



6.6.2 Not knowing where to get hepatitis A and B or mpox vaccination

Respondents who had not been vaccinated against hepatitis A (and who did not know they were immune to hepatitis A) (n = 213, 14.1 %), or who had not completed the course of vaccinations, or who did not know their hepatitis A vaccination status (collectively 29.6 % of all respondents) were asked: *"Do you know where you could get vaccinated against hepatitis A?"*. Similarly, respondents who had not been vaccinated against hepatitis B (and who did not know they were immune to hepatitis B), or who had not completed the course of

vaccinations, or who did not respond to the vaccination question, or who did not know their hepatitis B vaccination status (collectively 28.5 % of all respondents) were asked: *"Do you know where you could get vaccinated against hepatitis B?"*. Respondents who had not been vaccinated against mpox (collectively 64.3 %) were asked: *"Do you know where you could get vaccinated against mpox (monkeypox)?"*. **Table 6.12** shows the responses to these three questions.

Table 6.12 Knowledge of where to get hepatitis A and B or mpox vaccinations among respondents that could benefit from them

Knowledge where to get vaccinated	Against hepatitis A and/or B	Against mpox
No	14.0	30.9
Yes	67.5	57.7
Not sure	18.5	11.4
Total	**100**	**100**

Overall, 16.6 % of respondents who could benefit from hepatitis A vaccine and 6 % of respondents who could benefit from hepatitis B vaccine did not know where to access such vaccinations. For mpox the proportion of respondents not knowing where to access vaccination was 19.8 %.

6.6.3 Intentions in case of mpox outbreaks

All study participants were asked: *"If there was a rapid increase in mpox cases in your community, how likely would you take any of the following actions?"*

- *Get vaccinated against mpox [If not yet vaccinated]*
- *Avoid locations where spontaneous sex on the spot is possible*
- *Reduce the number of sexual partners/ avoid group sex*
- *Use condoms for anal intercourse more frequently*

Table 6.13 presents the proportion for each response across five intention categories for each preventive action.

Table 6.13 Protective intentions in case of mpox outbreaks

Protective intentions in case of mpox outbreaks	Very unlikely	Quite unlikely	Not sure	Quite likely	Very likely
Get vaccinated against mpox [If not yet vaccinated]	13.3	8.7	7.8	30.4	39.7
Avoid locations where spontaneous sex on the spot is possible	9.2	12.7	12.6	29.2	36.4
Reduce the number of sexual partners/ avoid group sex	9.7	12.0	10.7	28.4	39.1
Use condoms for anal intercourse more frequently	12.1	10.0	9.3	17.1	51.5

Across Switzerland, respondents reported being likely to adopt proactive measures in the event of an mpox outbreak, with particularly strong intentions for use condoms for anal intercourse more frequently (51.5 %) and more frequently get vaccinated against mpox [If not yet vaccinated] (39.7 %).

- Get vaccinated against mpox [If not yet vaccinated] (78 % vs. 22 %)
- Avoid locations where spontaneous sex on the spot is possible (78.1 % vs. 21.9 %)
- Reduce the number of sexual partners/ avoid group sex (78.3 % vs. 21.7 %)
- Use condoms for anal intercourse more frequently (77.9 % vs. 22.1 %)

6.7 Regional variation in key needs

Table 6.14 Regional variation in key needs

Qualifying cases	Switzerland	Score (mean) for the SIHS (0 to 6)*	% concerned about own drug use	% lacking control over safer sex	% lacking control over unwanted sex
1 509	**Overall Total**	**1**	**4.7**	**15.5**	**15**
	Regions				
313	Région lémanique	1.2	4.5	22.7	17.6
266	Espace Mittelland	1.1	7.1	17	16.2
197	Nordwestschweiz	1.0	3	14.2	11.7
486	Zürich	0.9	5.6	10.7	13.2
107	Ostschweiz	1.1	3.7	13.1	14
89	Zentralschweiz	1.0	(0)	(10.1)	(15.7)
35	Ticino	2.0	(0)	(34.3)	(28.6)
	Cities				
262	Zürich	0.8	5.7	12.2	14.5
157	Geneva-Lausanne	1.1	6.4	24.2	16.6

Numbers in parentheses ( ) indicate that the total number of respondents for that category is less than 100 (N < 100).
Numbers in brackets [ ] indicate that the total number of respondents is less than 20 (N < 20). *Short Internalised Homonegativity Scale

Table 6.15 Regional variation in key needs (continued)

Qualifying cases	Switzerland	Number (mean) of unknown HIV/STI transmission facts (0–6)	% not knowing u=U	Number (mean) of unknown PrEP facts (0–6)	% unaware of PrEP	Number (mean) of unknown HIV test/treat facts (0–7)	% not knowing where to test for HIV
1 509	**Overall Total**	**2**	**13.3**	**2**	**16.2**	**2**	**2.5**
	Regions						
313	Région lémanique	1.6	12.5	1.8	16	1.4	2.9
266	Espace Mittelland	1.8	16.6	1.9	16.7	1.5	1.1
197	Nordwestschweiz	1.9	14.7	1.7	13.6	1.7	4.1
486	Zürich	1.7	9.9	1.8	14.9	1.5	1.2
107	Ostschweiz	2.2	17.8	1.8	20.4	1.9	4.7
89	Zentralschweiz	2.0	(13.5)	1.9	(20.7)	1.9	(2.2)
35	Ticino	2.1	(20)	1.9	(20)	2.1	(11.4)
	Cities						
262	Zürich	1.7	8.4	1.7	10.8	1.6	1.1
157	Geneva-Lausanne	1.5	11.5	1.8	10.1	1.4	1.9

Numbers in parentheses ( ) indicate that the total number of respondents for that category is less than 100 (N < 100).
Numbers in brackets [ ] indicate that the total number of respondents is less than 20 (N < 20).

Table 6.16 Regional variation in key needs (continued)

Qualifying cases	Switzerland	Number (mean) of unknown hepatitis facts (0–5)	% not knowing where to get hepatitis a/B vaccination	Number (mean) of unknown HPV facts (0–3)	% not knowing that HPV vaccine exists	Number (mean) of unknown mpox facts (0–3)	% not knowing where to get mpox vaccination	% not knowing that mpox vaccine exists
1 509	**Overall Total**	**2**	**9.2**	**2**	**33.8**	**2**	**19.1**	**30.1**
	Regions							
313	Région lémanique	1.7	14.4	1.7	21.5	1.9	21	33
266	Espace Mittelland	1.7	8.3	2.1	37.3	2.1	22.9	31.4
197	Nordwestschweiz	1.6	9.6	2.2	40.7	1.7	22.4	34
486	Zürich	1.8	6.6	2.2	35.7	1.8	14.3	22.1
107	Ostschweiz	1.8	8.4	2.2	39	2.1	19	33.3
89	Zentralschweiz	1.8	(9)	2.3	(36.4)	1.9	(15.7)	(41.6)
35	Ticino	2.1	(8.6)	2.2	(28.6)	2.7	(31.4)	(42.9)
	Cities							
262	Zürich	1.8	5.3	2.1	27.6	1.8	9.2	17.2
157	Geneva-Lausanne	1.6	11.5	1.6	17.3	1.8	15.5	26.3

Numbers in parentheses ( ) indicate that the total number of respondents for that category is less than 100 (N < 100).
Numbers in brackets [ ] indicate that the total number of respondents is less than 20 (N < 20).

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Chapter 7: Interventions

To intervene means to take part in an activity in order to influence the course of events, usually making an outcome more or less likely. Within EMIS, relevant interventions are the actions of others that either support or undermine the health promotion needs described in **Chapter 6**.

Interventions may be positive (addressing needs) or negative (undermining needs and creating unmet need). Positive interventions include education, health and social services, as well as the many ways in which community members support one another. Negative interventions include homonegative legislation, exclusion, and abuse. Unlike in previous reports, we have included negative interventions in **Chapter 6** to improve readability for both NGOs (primarily concerned with needs) and European or governmental institutions (primarily concerned with the performance of health service interventions).

Effective sexual health strategies are grounded in a simple yet evidence-based logic:

1. Raise awareness about sexual health (Section 7.1)

Awareness-raising efforts include providing accessible, accurate, and culturally appropriate information on HIV, STIs, sexual well-being, and available prevention and care services. Education campaigns, programmes for and with key populations, peer-to-peer initiatives, and community outreach can empower individuals to make informed decisions and reduce stigma.

2. Vaccinate where effective vaccines exist and are recommended (Section 7.2)

Vaccination plays a key role in preventing sexually transmitted infections (STIs) such as hepatitis A, hepatitis B, HPV, and mpox, and should be implemented where efficacy is proven and public health guidelines support its use.

3. Protect where effective protective measures are available (Sections 7.3–4)

Protection interventions, including consistent condom use, pre-exposure prophylaxis (PrEP), and—if respective recommendations are implemented—doxycycline post-exposure prophylaxis (doxy-PEP) should be promoted where they have been shown to effectively reduce transmission.

4. Test and treat strategically (Sections 7.6–7)

Testing should be targeted based on the epidemiological situation to identify infections early. Treatment should aim to reduce individual suffering and be offered in cases where there is evidence of individual or public health benefit.

This chapter on intervention performance is divided into subchapters covering HIV/STI education services, vaccination interventions, protection interventions including access to condoms and pre-exposure prophylaxis services, testing interventions for HIV and STIs, treatment interventions, substance use services, and regional variation in interventions.

7.1 HIV/STI education services

Sexual health information—as well as health information more broadly—is more likely to be noticed, understood, and acted upon when it is tailored to the circumstances, identities, and (sexual) preferences of its key populations. For gay, bisexual and other men who have sex with men (MSM), as well as for trans and non-binary people, culturally competent and inclusive messages are particularly important, given the history of stigma and misinformation surrounding HIV and other sexually transmitted infections (STIs).

To assess the extent to which such targeted information currently reaches these groups, cis and trans MSM 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?”*; and trans and non-binary study participants were asked: *“When was the last time you saw or heard any information about HIV or STIs specifically for transgender people?”* Both groups were then offered a scale to indicate how recently this had occurred.

Table 7.1 Recency of seeing/hearing any information about HIV or STIs specifically for MSM / specifically for transgender people (MSM, N = 1419, missing n = 0; Transgender, N = 112, missing n = 0)

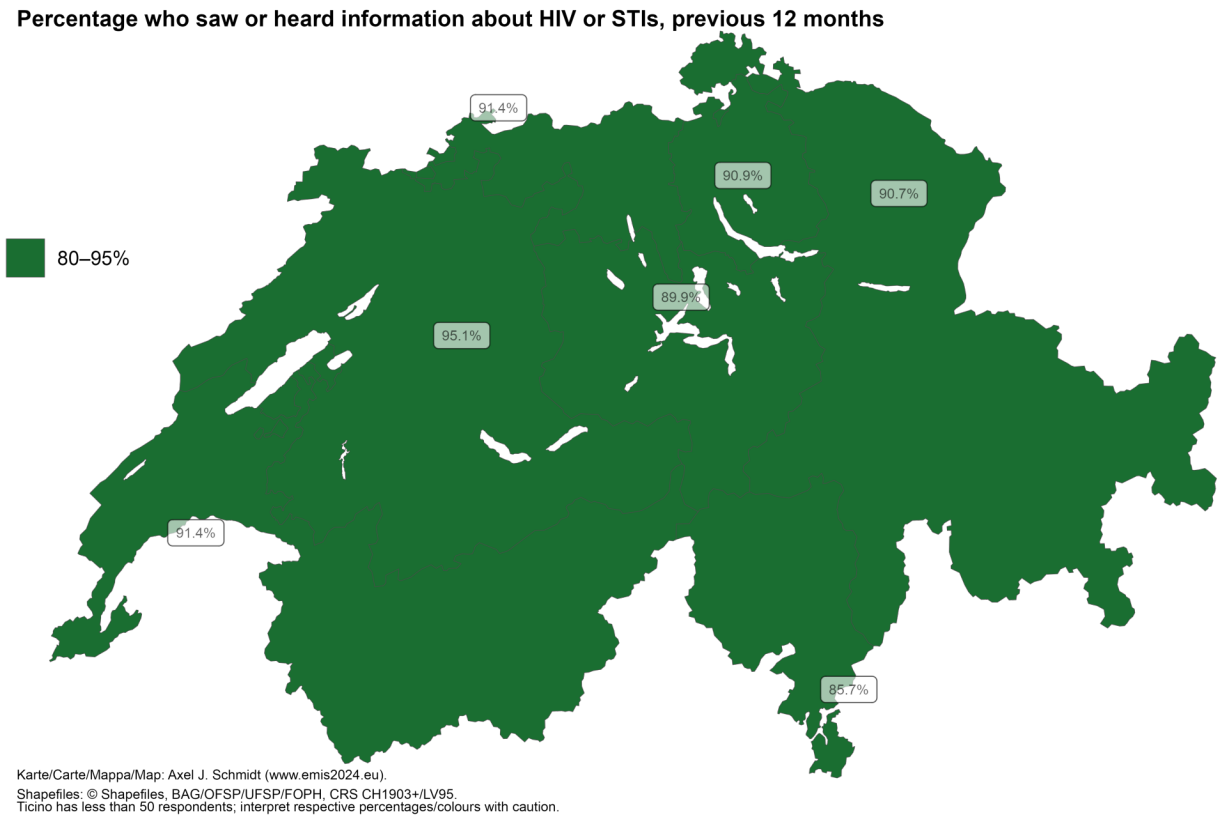
Last encounter with HIV/STI information	% (MSM)* N = 1451	Cumulative % (MSM)	% (transgender / non-binary)** N = 112	Cumulative % (transgender / non-binary)
Within the last 24 hours	10.7	10.7	5.4	5.4
Within the last 7 days	24.1	34.8	9.8	15.2
Within the last 4 weeks	25.5	60.3	13.4	28.6
Within the last 6 months	24.1	84.4	25.9	54.5
Within the last 12 months	8.1	92.5	9.8	64.3
Within the last 5 years	4.0	96.5	5.4	69.7
More than 5 years ago	2.5	99.0	2.7	72.4
Never	1.1	100.1	27.7	100.1
Total	**100**		**100**	

* Missing n = 0; ** Missing n = 0

Almost all cis and trans MSM (92.2 %) had seen MSM-specific information about HIV or STIs in the past 12 months, and around three out of five MSM (60.2 %) had done so in the past four weeks. Among trans and non-binary respondents, the corresponding proportions for exposure to transgender-specific information were 64.3 % and 28.6 %.

When combining the answers for MSM and trans/non-binary respondents, 91.5 % had seen MSM- or trans-specific information about HIV or STIs in the previous 12 months. **Map 7.1** shows reported exposure to MSM- or transgender-specific information on HIV and STIs, with very little variation across Switzerland.

Map 7.1: Percentage who saw or heard information about HIV or STIs for specifically MSM, previous 12 months (N = 1509)



7.2 Vaccination interventions

Effective vaccines are available for both hepatitis A and B. Vaccines against human papillomavirus (HPV) have been in use for many years, but vaccination recommendations and reimbursement policies for MSM, as well as for trans and non-binary people vary widely across European countries. An attenuated poxvirus vaccine has been approved for protection against mpox, though its availability during the 2022 European mpox outbreak varied considerably between countries. Completing a full vaccination course—whether for hepatitis, HPV, or mpox—can be considered a form of precautionary sexual health behaviour. In this context, vaccination coverage is presented as the outcome of a public health intervention rather than an individual-level behavioural choice.

All study participants were asked:

- *"Have you been vaccinated against hepatitis A?"*
- *"Have you been vaccinated against hepatitis B?"*
- *"Have you been vaccinated against mpox since May 2022?"*

All participants who positively answered knowing about vaccines against HPV were asked:

- *"Have you been vaccinated against HPV?"*

The responses offered and the percentages indicating each are set out in **Tables 7.2–7.4**.

7.2.1 Offers of hepatitis vaccination

All study participants were asked: *"Have you ever been offered any hepatitis vaccination by a health service?"* Overall, 73.8 % answered *"Yes"*, 20.1 % answered *"No"* and 6.1 % answered *"I don't know"* (N = 1509, missing n = 0). Excluding those who did not know, 78.6 % had ever been offered hepatitis vaccination by a health service.

7.2.2 Hepatitis A and B vaccination coverage

When excluding respondents with a history of hepatitis A and/or hepatitis B, 69.1 % in Switzerland reported a full course of hepatitis A vaccination, and 71.9 % reported a full course of hepatitis B vaccination. We counted *"Yes and I completed the course"* for hepatitis A, and *"Yes and I completed the course"* as well as *"Yes but I did not respond to the vaccine"* for hepatitis B. As the number of shots recommended for hepatitis B vaccination varies according to age and product and, as during the 2017 hepatitis A outbreaks among MSM [1,2], the recommended number of shots was reduced from two to one due to scarceness of vaccine availability [3], the questionnaire did not specify the number of shots needed to *"complete the course"* of vaccination.

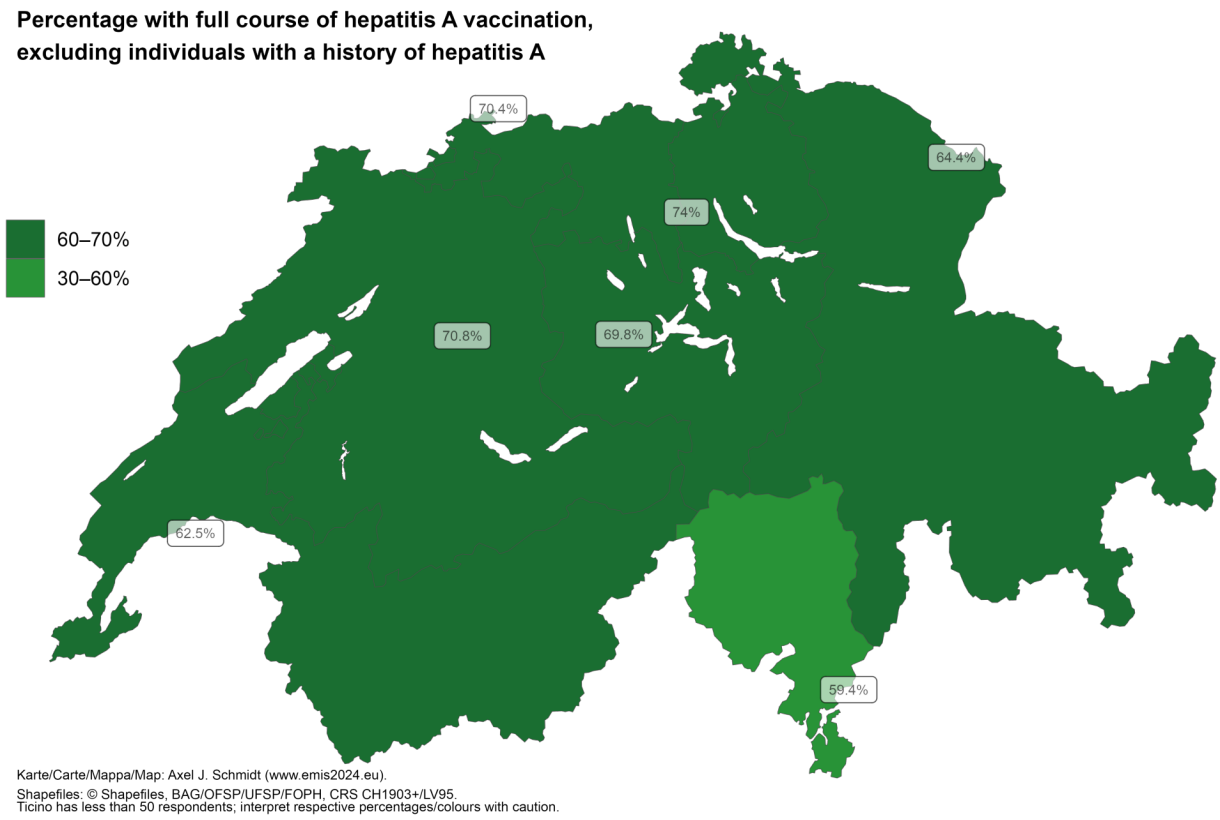
Table 7.2 Hepatitis A and B vaccination status (hepatitis A, N = 1504; hepatitis B, N = 1509)

Hepatitis vaccination status	% vaccinated against hepatitis A N = 1504	% vaccinated against hepatitis B** N = 1509
No, because I've had hepatitis A/B (and am now naturally immune)	3.9	3.0
No, and I don't know if I'm immune	14.2	11.3
Yes, and I completed the course	66.4	68.5
Yes, but I did not complete the course	2.3	1.9
I don't know	13.2	14.0
No, I have chronic hepatitis B infection	-	-
Yes, but I did not respond to the vaccinations	-	1.3

* Missing n = 5; ** Missing n = 0

Given the extensive media coverage of hepatitis A outbreaks among MSM across Europe between June 2016 and May 2017 [3], reporting on hepatitis A vaccination is likely to be more reliable than in earlier surveys (*e.g.*, EMIS-2010). However, it remains unclear how sustainable such media-driven awareness is over time. Most of the European countries affected by the outbreaks routinely recommended hepatitis A vaccine for MSM. Yet, seven years after the media attention, 69.1 % of MSM reported having been vaccinated. **Map 7.2** illustrates hepatitis A vaccination coverage with minor variation across Switzerland.

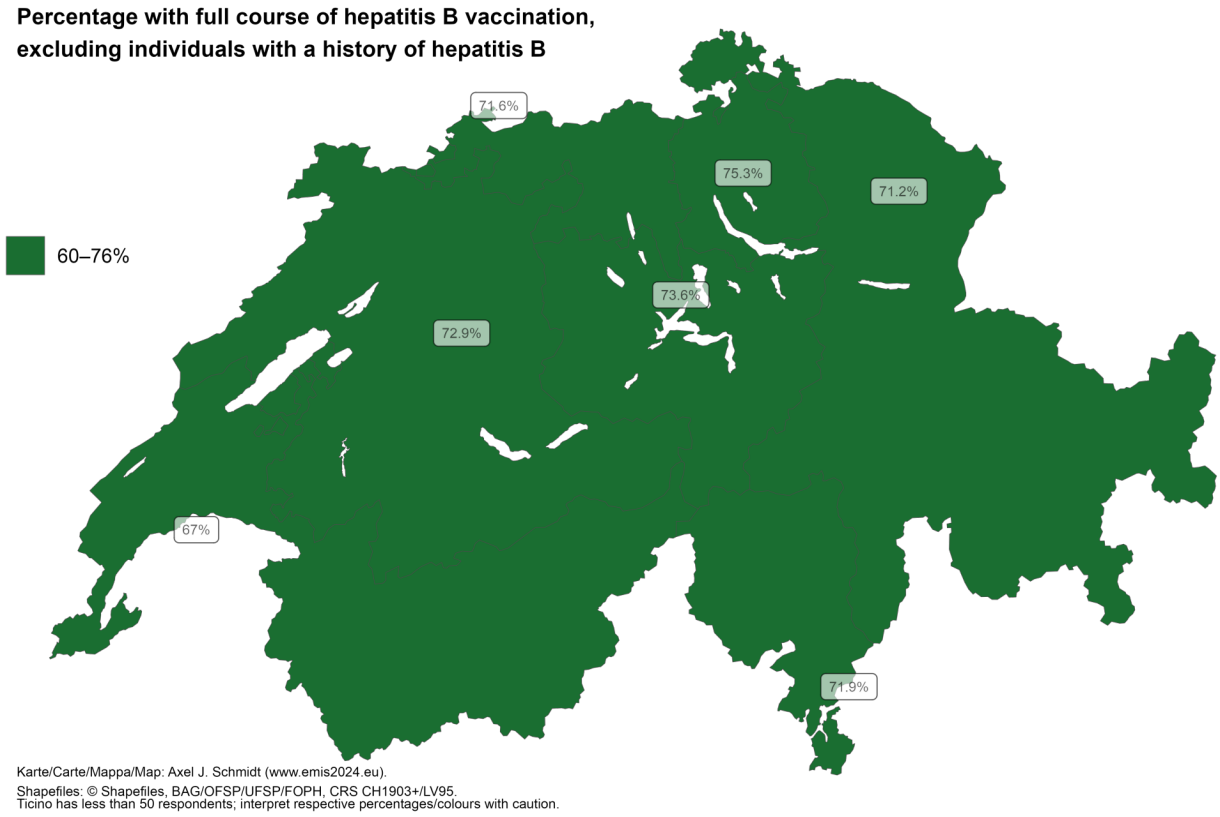
Map 7.2 Percentage with full course of hepatitis A vaccination, excluding respondents with a history of hepatitis A (N = 1504, missing n = 5)



When respondents who were unsure about their hepatitis A vaccination status are excluded, the proportion of respondents reporting having completed the course increased from 69.1 % to 80.2 % for hepatitis A.

While hepatitis A vaccination is recommended for adults at increased risk of infection (*e.g.*, MSM), the situation differs for hepatitis B. Almost all countries within the WHO European Region recommend universal childhood vaccination against hepatitis B [4]. Thus, younger generations (who received hepatitis B vaccination as a child) might not always be aware of their hepatitis B vaccination status. **Map 7.3** illustrates hepatitis B vaccination coverage with minor variation across Switzerland.

Map 7.3 Percentage with full course of hepatitis B vaccination, excluding respondents with a history of hepatitis B (N = 1509, missing n = 0)



When respondents who were unsure about their hepatitis B vaccination status are excluded, the proportion of respondents reporting having completed the course increased from 71.9 % to 84.1 % for hepatitis B.

7.2.3 HPV vaccination coverage

Human papillomavirus (HPV) vaccination has been introduced across Switzerland as a key measure to prevent HPV-related cancers and genital warts. Most European countries now offer HPV vaccination programmes for adolescents, typically targeting girls, with an increasing number extending coverage to boys. Despite these efforts, uptake and programme implementation vary considerably between countries, influenced by factors such as national policy, healthcare infrastructure, and public awareness. Monitoring vaccination coverage and understanding barriers remain essential to maximise the public health benefits of HPV immunisation. Only respondents who knew that a vaccine against HPV exists were asked if they were vaccinated. **Table 7.3** shows the distribution of answers. Across Switzerland, 31.6 % reported having received at least one shot of HPV vaccine, and 24.1 said they would have wanted to if it had been available for their gender or age.

Table 7.3 HPV vaccination status (N = 981)

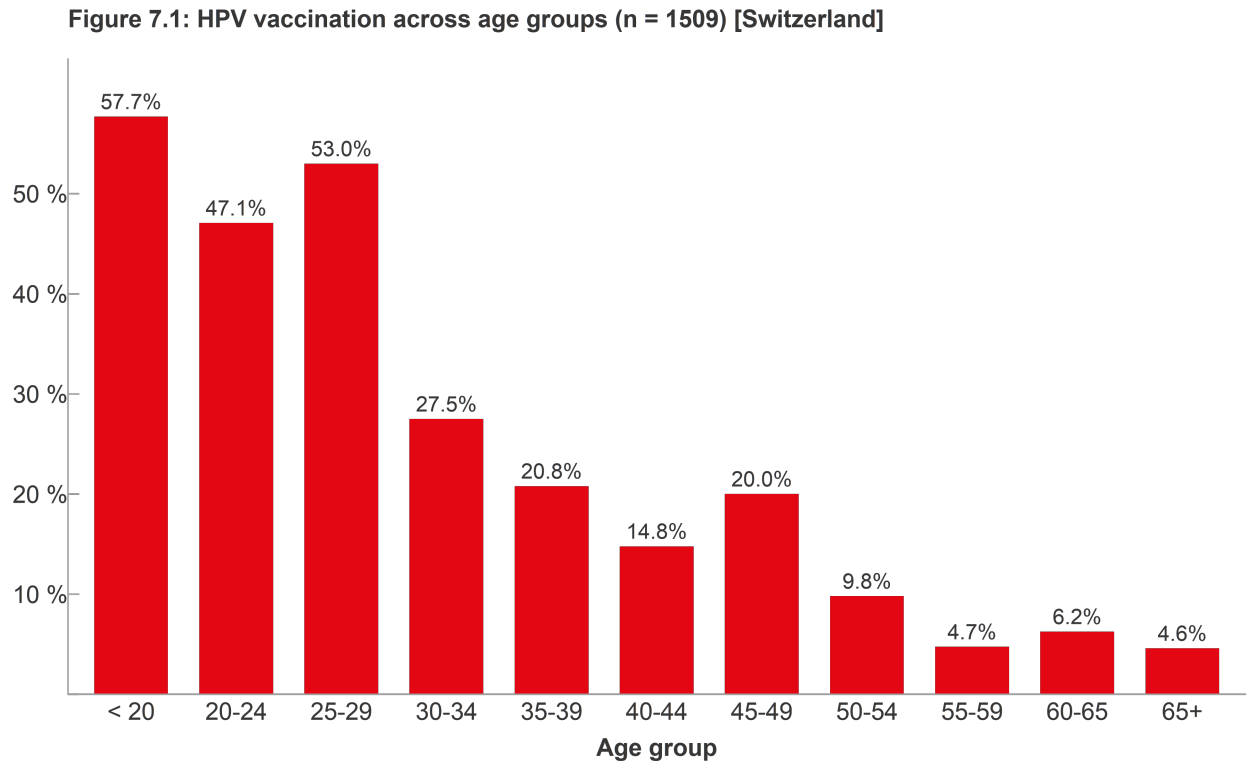
HPV vaccination status N = 981	% vaccinated against HPV*
No, I did not want to	27.6
No, I wanted to but it was not available to me because of my gender or my age	24.1
No, I wanted to but I could not afford it	5.2
Yes, at least one shot	31.6
I don't know	11.5

* Missing n = 6

The recommended age for HPV vaccination in males varies across Europe [5]. In most countries, boys are offered vaccination in early adolescence, typically between 11 and 14 years, though some countries provide

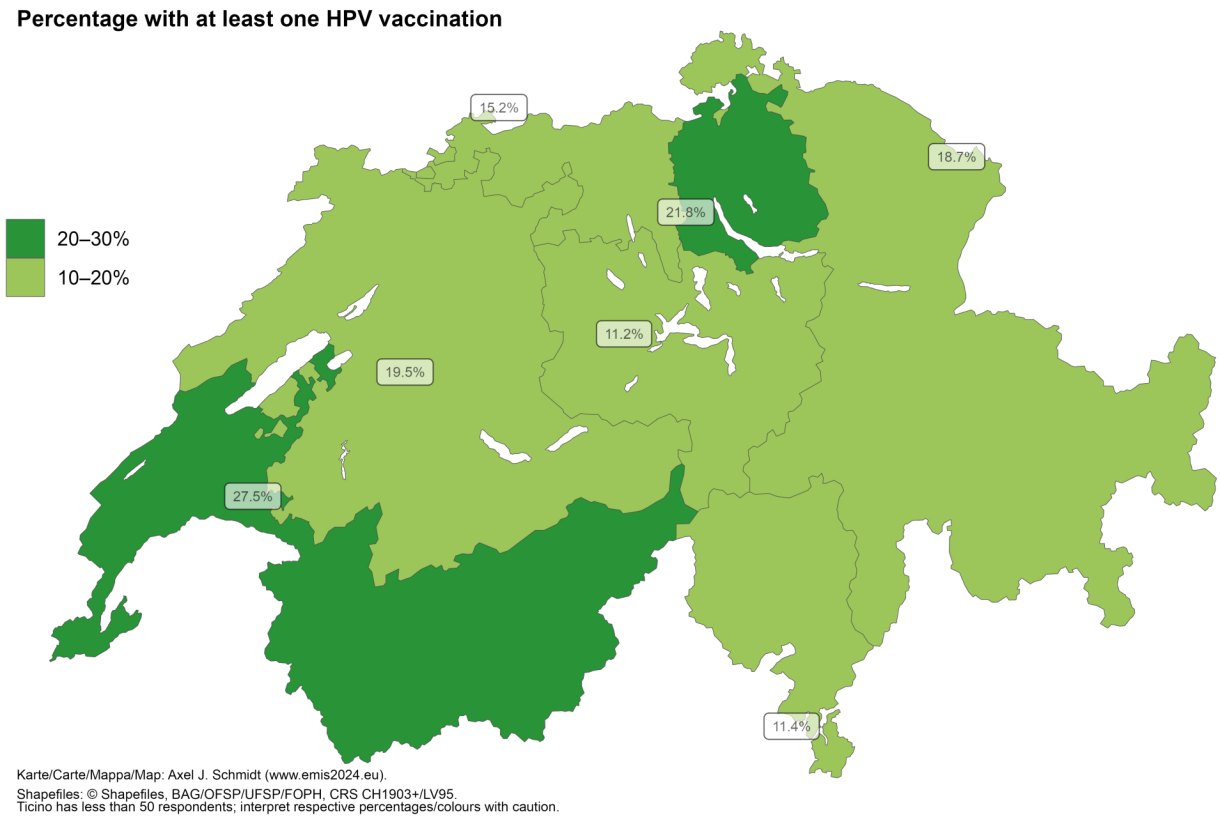
catch-up programmes for older adolescents and young adults. In the United Kingdom, for example, vaccination is recommended for MSM and trans people up to age 45, while in Switzerland it is recommended up to age 26. In most other countries, the recommended upper age limit is lower. Given the relatively recent introduction of HPV vaccination recommendations for boys (*e.g.*, UK 2019 [6]; Switzerland 2015 [7]), vaccination coverage shows a pronounced age gradient, as illustrated in **Figure 7.1**. Respondents who were unaware of the existence of an HPV vaccine were counted as unvaccinated.

Figure 7.1 Percentage with HPV vaccination, by age group (N = 1503, missing n = 6)



In Switzerland, respondents aged 34 years and younger in 2024 fell within the eligible age range for HPV vaccination. **Map 7.4** illustrates HPV vaccination coverage with considerable variation across Switzerland.

Map 7.4 Percentage with at least one HPV vaccination (N = 1503, missing n = 6)



7.2.4 Mpox vaccination coverage

Mpox emerged as a notable public health concern in Europe in 2022, predominantly affecting men who have sex with men (MSM) [8,9]. Transmission occurred mainly through close physical and sexual contact [10–12], and several European countries implemented targeted vaccination campaigns and public health interventions for groups at high risk for infection. Despite these efforts, the epidemic highlighted substantial differences in preparedness, vaccination strategies, and outbreak response across countries.

For EMIS-2024, we introduced a new question on mpox vaccination, asking: *"Have you been vaccinated against mpox ('monkeypox') since May 2022?"* **Table 7.4** presents the responses. Around one out of two respondents (55.6 %) reported that they did not feel the need for vaccination, while around one in eleven (8.9 %) indicated that the vaccine was not available to them when they needed it.

Table 7.4 Mpox vaccination status (N = 1503)

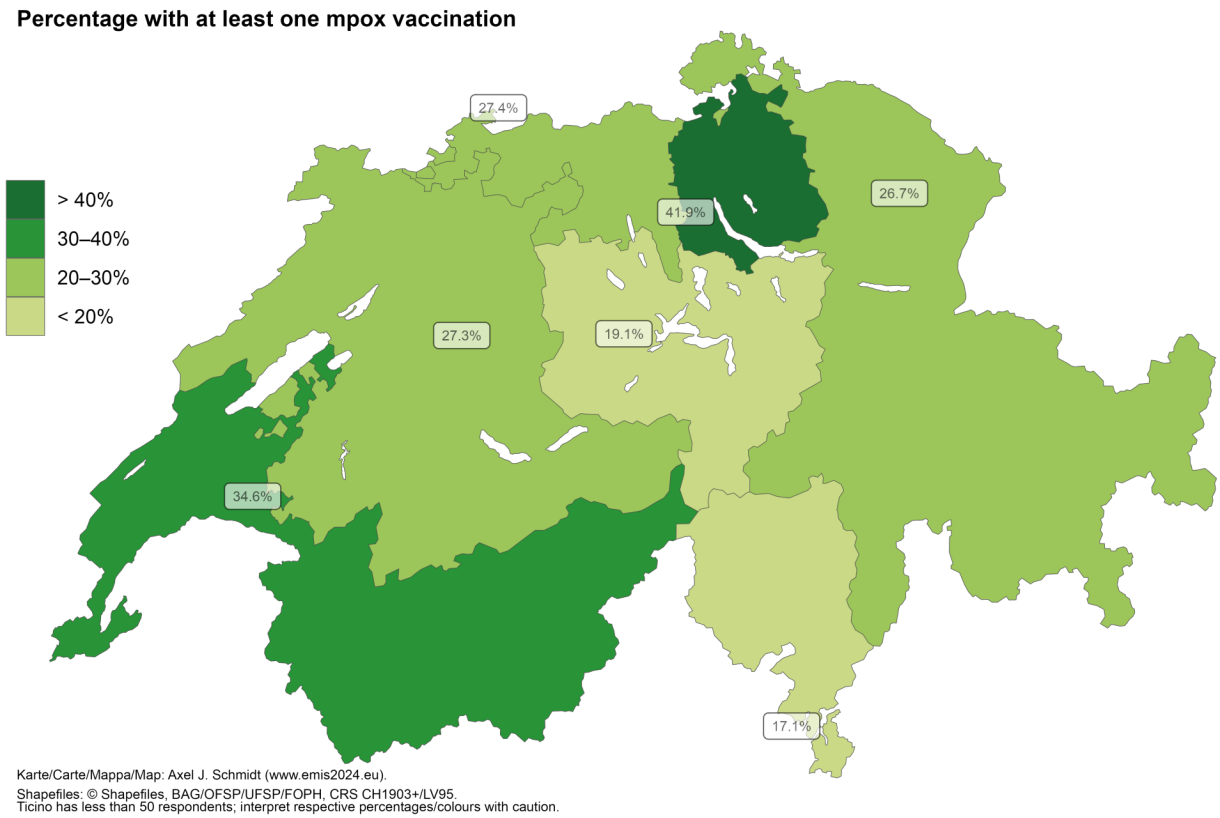
mpox vaccination status N = 1503	% vaccinated against mpox*
No, I did not want to	55.6
No, I wanted to, but it was not available to me	8.9
Yes – with one dose	7.3
Yes – with two doses	24.6
Yes – but I am not sure how many doses	0.9
I don't know	2.7

* Missing n = 6

Respondents not yet vaccinated against mpox were asked, *"Do you know where to go to get vaccinated against mpox ('monkeypox')?"*, and 30.9 % said *"No"*, and another 11.4 % were not sure.

Overall, 32.7 % of respondents reported having received at least one mpox vaccination. A full vaccination course—defined as two doses for most respondents, or one dose for those aged 50 years or older—was reported by 29.7 %. **Map 7.5** shows the uptake of at least one dose, highlighting considerable variation across Switzerland.

Map 7.5 Percentage with at least one mpox vaccination since May 2022 (N = 1503, missing n = 6)



Karte/Carte/Mappa/Map: Axel J. Schmidt (www.emis2024.eu).

Shapefiles: © Shapefiles, BAG/OFSP/UFSP/FOPH, CRS CH1903+/LV95.
Ticino has less than 50 respondents; interpret respective percentages/colours with caution.

7.3 Protection interventions: Access to condoms

For the longest time in HIV prevention interventions, condom distribution has been a key intervention for increasing access to condoms, and condom packs often carry health promotion information on or inside their packaging. All study participants were asked, *"Where have you got condoms from in the last 12 months?"*, and were asked to tick as many as responses as were appropriate from the range of sources in **Table 7.5** below.

Table 7.5 Sources of condoms in the previous 12 months

Source of condoms N = 1507	All respondents*
Bought online	14.3
Bought at physical shop	52.6
Bought from vending machine	4.2
Received from clinics	6.8
Received from gay/LGBTQ+ bars/clubs	17.8
Received from saunas	15.8
Received from community organizations	17.0
Received from friends/sex partners	10.9
Other	1.9
Did not get condoms	21.5

* Missing n = 2

The most common source of condoms was purchasing them from a physical shop, which was reported by around one out of two respondents (52.6 %). The remaining respondents relied on a variety of other sources.

One of the *Dublin Declaration Monitoring* indicators for HIV assesses the extent of condom promotion and distribution among MSM. To construct this indicator, we combined reports of respondents receiving free condoms from community organisations, clinics, bars, or saunas. Overall, 35.4 % of respondents reported receiving condoms from at least one of these sources in the past year.

7.4 Protection interventions: HIV-PrEP services

Understanding and accessing HIV-PrEP (pre-exposure prophylaxis) requires educational interventions and services that will supply the pills or provide information on where to get them or how to order them online. While in some countries PrEP can be prescribed within national health systems, in other countries, this is not possible, and private supplies must be sourced. In some countries neither of these options is available.

7.4.1 Speaking to MSM, trans and non-binary people about PrEP

All study participants were asked: *"Has anyone at a health service in Switzerland ever spoken to you personally about PrEP?"* Those who answered *"Yes"* were then asked, *"Which health service has spoken to you about PrEP?"*, with the response options shown in **Table 7.6**. For this analysis, we focus on respondents not diagnosed with HIV. Among them, 49.5 % reported that someone at a health service in their country had spoken to them about PrEP.

Few respondents reported contact with more than one type of service. Across Switzerland, the most common services discussing PrEP were community services or drop-ins (45.4 % of all respondents), outpatient services at hospitals or clinics (8.4 %), and doctors in private practice / general practitioners (22.7 %). Among respondents who had discussed PrEP at a health service, the proportions were substantially higher, while the relative ranking of services was largely unchanged. Differences between countries were large, but within countries variation was minor, reflecting national health-care organisation.

Table 7.6 Health service having spoken to participants about PrEP (for all without diagnosed HIV)

Health service having spoken about PrEP	% of all respondents not diagnosed with HIV who had been spoken to about PrEP* N = 668	% respondents not diagnosed with HIV* N = 1351
	%	%
At a community service or drop-in	71.1	45.4
A doctor in private practice	15.6	12.7
General Practitioner / family doctor	15.1	10.0
At a hospital or clinic as an outpatient	12.9	8.4
At a gender-affirming care service	0.4	0.2
Other	4.5	2.1

7.4.2 Consulting a healthcare professional before using PrEP

Access to PrEP is not only about availability of medication, but also about the quality of information and support surrounding its use. Talking to a healthcare professional before starting PrEP can influence adherence, monitoring, and overall effectiveness. Respondents who had ever taken PrEP were asked: *"Did you speak to a healthcare professional about PrEP before using it?"* Overall, 97.3 % of respondents who had taken PrEP (N = 477, missing n = 1) indicated *"Yes"*, that they had spoken to a health professional before taking PrEP.

7.4.3 Where are PrEP pills coming from?

Understanding how people obtain PrEP offers insights into accessibility, affordability, and health system preparedness. Sources of PrEP use can highlight gaps between official provision and community demand. Study participants who had ever taken PrEP were asked: *"Where have you got your PrEP pills from?"* The responses are shown in **Table 7.7**. Even in 2024, eight years after the first PrEP implementation in Europe (France) and following gradual rollout and public reimbursement starting around 2016–2018 (*e.g.*, Belgium, Germany, Israel, Luxembourg, the Netherlands, Norway, Portugal, Spain, Sweden, and the UK), a large proportion of respondents in some countries still received PrEP *"as a participant in a research study"*.

For example, this was reported by 51.7 % of respondents in Switzerland.

In contrast, 46 % of respondents reported receiving PrEP at a community health service across Switzerland.

Informal ways of obtaining PrEP—such as using PEP pills as PrEP, using someone else's ART, or receiving PrEP pills from a friend or sexual partner—were reported by 2.9 % of respondents across Switzerland.

Table 7.7 Source of PrEP pills among study participants who had ever taken PrEP

Source of PrEP N = 478	% of all respondents*
As a participant in a research study	51.7
General Practitioner / family doctor	9.8
A doctor in private practice	13.6
At a hospital or clinic	9.4
At a community health service or drop-in	46.0
From an online pharmacy/abroad	14.9
From a physical pharmacy in the country	13.0
Used PEP pills as PrEP	0.2
Used someone else's ART pills as PrEP	0.4
Given by friend or partner	2.3
At a gender-affirming care service	5.0
Other	2.3

* Missing n = 1031

7.4.4 Involuntary interruptions of PrEP

Around the turn of 2023 to 2024, some people using HIV pre-exposure prophylaxis (PrEP) in Europe experienced interruptions in their medication. These disruptions arose from a range of factors, including difficulties in accessing health services during the COVID-19 pandemic, but were mainly driven by global shortages of PrEP caused by challenges in production, packaging, and transport logistics, alongside other personal or structural barriers to consistent use.

Understanding the frequency and reasons for such interruptions is important for assessing gaps in HIV prevention and ensuring equitable access to PrEP. In EMIS-2024, we therefore asked all study participants who had ever taken PrEP: *"When was the last time you experienced an involuntary interruption of your PrEP medication?"* A clear majority respondents (86.8 %) answered *"Never"*, but around one in eleven (8.6 %) reported an involuntary PrEP interruption around 2023/24. Reports of interruptions in other years were less frequent and varied by country.

7.4.5 Using antibiotics for prevention certain bacterial STIs

Doxy-PEP (doxycycline post-exposure prophylaxis) is an emerging prevention strategy aimed at reducing the incidence of certain bacterial STIs, particularly syphilis and chlamydia. It involves taking a single dose of doxycycline within 24 hours after sex. While research from the United States [13] and France [14] has demonstrated promising reductions in bacterial STI rates among MSM, as well as some trans women, the

approach has not yet been widely adopted in Europe. Current discussions focus on its effectiveness, potential antibiotic resistance [15], and how it could fit into broader sexual health strategies [16].

Respondents who had used antibiotics for STI prophylaxis in the past 12 months were asked: *"Where did you get your antibiotics from?"* The responses are summarised in **Table 7.8**. As most antibiotic prophylaxis is likely to have been taken as doxy-PEP, we use this term throughout the report. For any informal use, however, we place the term in quotation marks (‘ ’), as the exact antibiotic used cannot be confirmed.

Table 7.8 Sources of antibiotics for STI prevention (‘doxy-PEP’)

Antibiotics for STI prevention (‘doxy-PEP’) N = 119	% of respondents using 'doxy-PEP'*
Prescribed by healthcare provider for STI prevention	58.0
Bought in pharmacy without prescription	6.7
Leftover from previous prescription	23.5
From sexual partner/friend/acquaintance	5.9
From drug dealer	0.8
Bought online or abroad	10.9
Other source	7.6

* Missing n = 1

Around three out of five respondents (58 %) reported being prescribed doxy-PEP for STI prevention by a healthcare provider, while around one in two (48.7 %) reported using doxy-PEP informally or outside of a prescription.

7.5 Testing interventions: HIV testing services

In recent years the regulations regarding HIV testing have been relaxed in many European countries, and HIV tests can be accessed in a variety of settings, including community-based testing (often in the absence of physicians via trained personnel), self-sampling and self-testing. This section considers how far HIV testing is penetrating, which services are providing the tests, whether respondents are satisfied with them and whether health services are pro-active in offering HIV tests.

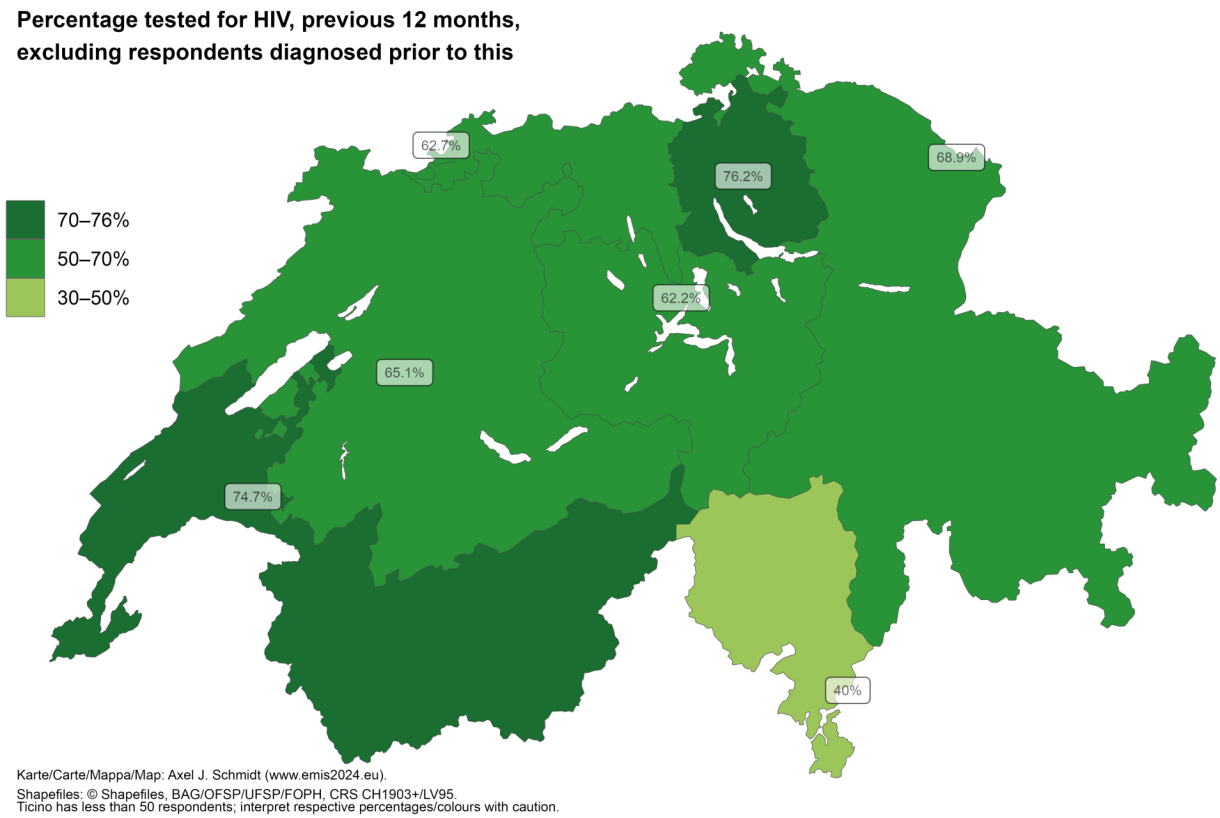
7.5.1 HIV test offers by health services and HIV testing uptake

Study participants were asked: *"Have you ever received an HIV test result?"* Overall, 90.6 % (N = 1509, missing n = 0) indicated that they had received a test result. In contrast, around one in nine (9.4 %) answered *"No"* indicating they had never received an HIV test result. Among this group, 70.4 % reported that they had never been offered an HIV test by a health service (N = 142, missing n = 0).

Conversely, around one in 25 (3.8 %) reported that they had been *"forced or tricked into taking an HIV test"* when they did not want to take one.

Excluding respondents who had already been diagnosed with HIV more than 12 months ago, 69.5 % (N = 941) had received an HIV test result in the previous 12 months. For comparisons with testing for other STIs see **Section 7.9**. **Map 7.6** shows HIV testing uptake, highlighting considerable variation across Switzerland.

Map 7.6 Percentage tested for HIV, last 12 months, excluding those diagnosed prior to this (N = 941)



7.5.2 Settings for HIV testing and diagnosis

Where people access HIV testing has important implications for reach, equity, and linkage to care. Examining the settings in which tests and diagnoses occur helps identify both the role of mainstream healthcare services and the contribution of community-based approaches.

Study participants who had been diagnosed with HIV were asked, *"Where were you initially diagnosed with HIV?"* and respondents whose last test was negative were asked: *"Where did you go for your last HIV test?"* Both were offered the responses in **Table 7.9**.

Table 7.9 Setting of last HIV test for MSM whose last test was negative, and setting of first HIV diagnosis among those who tested positive for HIV

Settings for HIV testing	Location of last HIV test* N = 1209	Location of initial HIV diagnosis** N = 146
At a community health service or drop-in (not in a hospital or clinic)	44.3	19.2
General Practitioner / family doctor	24.3	42.5
A doctor in private practice	9.8	14.4
At a hospital or clinic as an out-patient	9.5	14.4
At a hospital as an in-patient	1.7	6.2
I used a self-sampling kit (I took my own sample then sent it away to be analysed)	3.8	0.7
At a gender-affirming care service	2.1	1.4
At a mobile testing unit	2.0	0.7
At a blood bank, while donating blood	1.3	0.7
I used a self-testing kit (I found out the result on the spot)	0.7	0.0
In a bar/pub, club or sauna	0.3	0.0
Elsewhere	0.2	0.0
Total	**100**	**100**

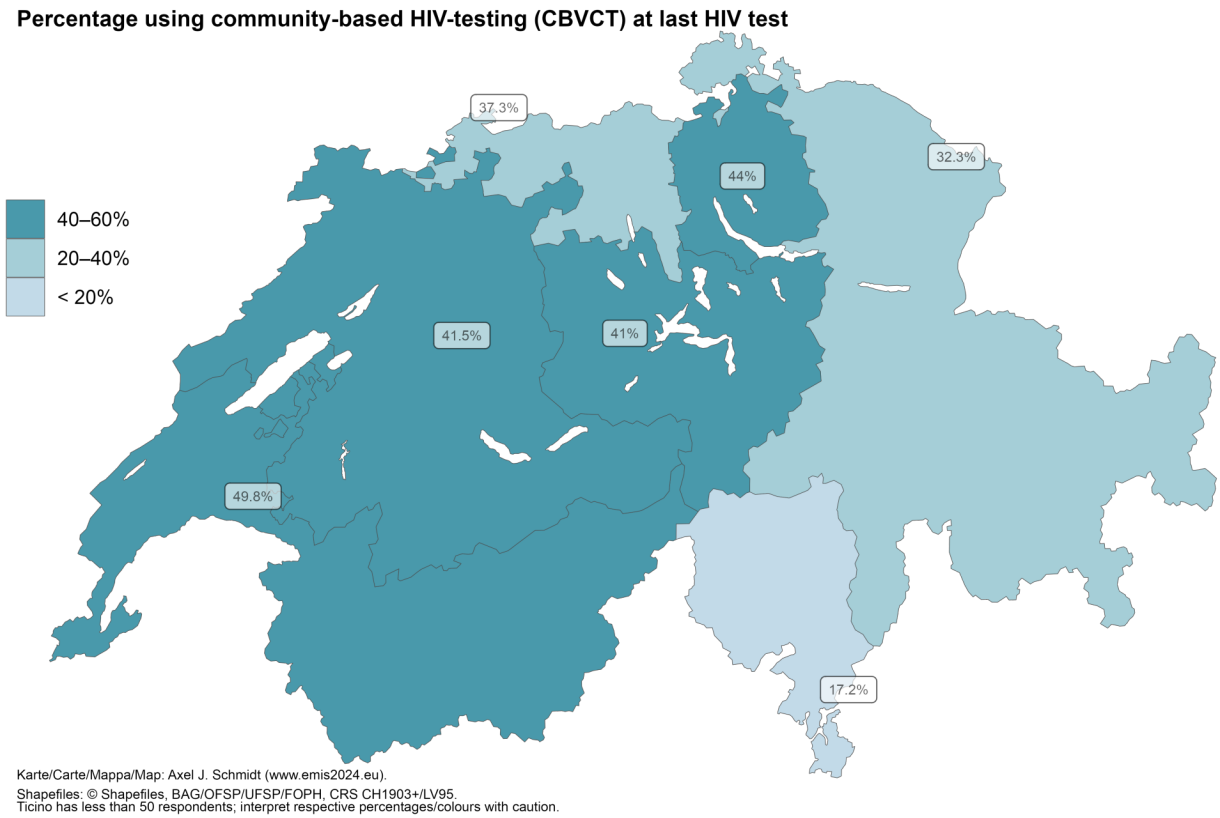
* Missing n = 0; ** Missing n = 0

HIV tests were provided across a range of service settings, with no single type of setting dominating. Respondents most commonly received an HIV test at a private practice—combining general practitioners and other private doctors—which accounted for 33.8 % of last tests among those who tested negative, and 56.9 % among HIV-diagnosed respondents). This was followed by a hospital or clinic (outpatient and inpatient taken together accounted for 46 % when the last test was negative, and 25.4 % among HIV-diagnosed respondents).

Thus, clinical settings still dominate HIV-testing in Switzerland, whether this is an outpatient service at a hospital or in private practice. Which of the two clinical settings is dominant in a specific country depends largely on the healthcare system of that country.

The third most common setting for HIV testing was through community health services. **Map 7.7** shows the proportion of CBVCT testing across Switzerland, highlighting considerable variation within Switzerland.

Map 7.7 Percentage using community HIV testing at last HIV test (N = 1367)



Despite existing deferral policies for MSM (or for engaging in anal intercourse) in many European countries, almost 2.1 % had had their last (negative) HIV test while donating blood [17].

HIV self-sampling and HIV self-testing had been used by 1.3 % and 3.8 %, respectively, of respondents whose last test was negative; and by 0.7 % and 0.7 %, respectively, of respondents who were diagnosed positive.

When asked, *"What would be your first choice for HIV testing, if you could choose freely?"*, responses were broadly similar across options, except for a lower proportion preferring a hospital setting (4.5 %), and higher proportions choosing self-sampling (3.1 %) or self-testing (10.1 %).

7.5.3 Acceptability of post-HIV test support

The experience of HIV testing goes beyond the test result itself; the support and information provided afterwards can shape how people understand their status, cope with the outcome, and engage with follow-up care. Assessing satisfaction with post-test support highlights both the strengths and the shortcomings of current testing services.

Study participants who had been diagnosed with HIV were asked, *"When you were diagnosed HIV positive, how satisfied were you with the support and information you received?"* and respondents whose last HIV test was negative were asked: *"The last time you tested for HIV, how satisfied were you with the support and information you received?"* Both were offered the responses in **Table 7.10**.

Table 7.10 Satisfaction with support and information received during testing

Satisfaction with support and information received during HIV testing	Last HIV test was negative	Diagnosed HIV
I did not receive any support or information	6.8	11.7
Very satisfied	48.6	56.3
Satisfied	27.4	22.0
Dissatisfied	7.5	1.5
Very dissatisfied	6.2	1.7
I don't remember / I did not think about it	3.4	6.7
Total	**100**	**100**

Respondents were more likely to receive support or information if they were diagnosed with HIV than if they were not. However, around one in 14 respondents with diagnosed HIV (6.8 %) still received no support or information.

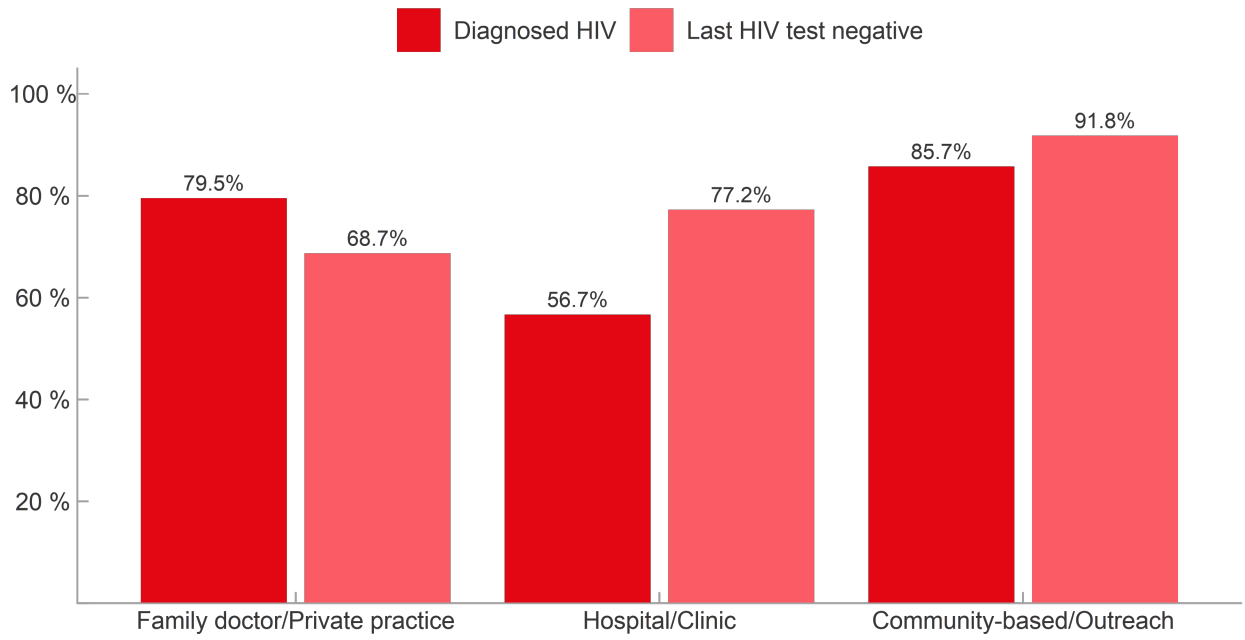
Overall, 13.7 % of respondents who tested positive, compared with 3.2 % of respondents who tested negative, were dissatisfied with the support or information received.

As **Figure 7.2** demonstrates, a slightly higher proportion of respondents were satisfied or very satisfied with the support and information they received during HIV testing, if they had tested in the previous year compared to respondents that had not tested in the previous year. The graph also demonstrates that satisfaction was highest among respondents reporting that their last HIV test was community-organised, either at a drop-in or during outreach.

Figure 7.2 Percentage satisfied or very satisfied with support and information received at last HIV test (N = 1355, missing n = 0)

Figure 7.2: Satisfaction with support and information received at last HIV test [Switzerland]

Diagnosed HIV (n = 146); Last HIV test negative (n = 1209)



7.6 Testing interventions: STI testing services

7.6.1 Awareness of client's sexuality among STI test providers

Whether healthcare providers are aware of a client's sexual behaviour can affect the quality of sexual health care they deliver, including the tests offered and the advice provided. Exploring disclosure and awareness helps to highlight barriers to open communication and potential gaps in STI prevention and treatment.

Study participants who had had an STI test in the previous year were asked: *"On that occasion (at the last test), did your healthcare provider know you have sex with men?"* **Table 7.12** shows the possible responses and the proportions indicating each.

Table 7.12 Disclosure of sex with men to healthcare provider during an STI test

Disclosure of sex with men to healthcare provider during an STI test	% of all respondents
Yes, they definitely knew	87.5
Yes, they probably knew	5.7
No, they did not know	5.2
I don't know whether they knew or not	1.6
Total	**100**

A clear majority respondents (87.5 %) who had undergone an STI test in the previous 12 months felt confident that their healthcare provider was definitely aware they had sex with men, while around one in 20 (5.2 %) reported that their provider was not aware.

7.6.2 Uptake of STI testing

Regular STI testing is central to prevention, early diagnosis, and timely treatment, yet patterns of uptake vary across populations and over time. Examining both lifetime and recent testing helps to identify groups with better access to routine screening as well as those more likely to test only when symptoms occur.

All study participants were asked: *"Have you ever had a test for sexually transmitted infections (STIs) other than HIV?"* Overall, across Switzerland, 82.1 % answered *"Yes"*, 16 % answered *"No"* and 1.9 % answered *"I don't know"*. When those who did not know were excluded, 83.7 % had ever had a test for STIs other than HIV.

Respondents who answered *"Yes"* were asked, *"When did you last have a test for STIs other than HIV?"*, with a scale to indicate how recently this had occurred. Overall, 65.5 % of respondents had had an STI test in the previous 12 months.

Figure 7.3 shows these recency responses across four groups:

1. PrEP users, who in most European countries are recommended to have STI screening every three months
2. Respondents with diagnosed HIV, who are recommended to be screened for syphilis every six months
3. Other respondents who have ever tested for HIV
4. Other respondents who have never tested for HIV

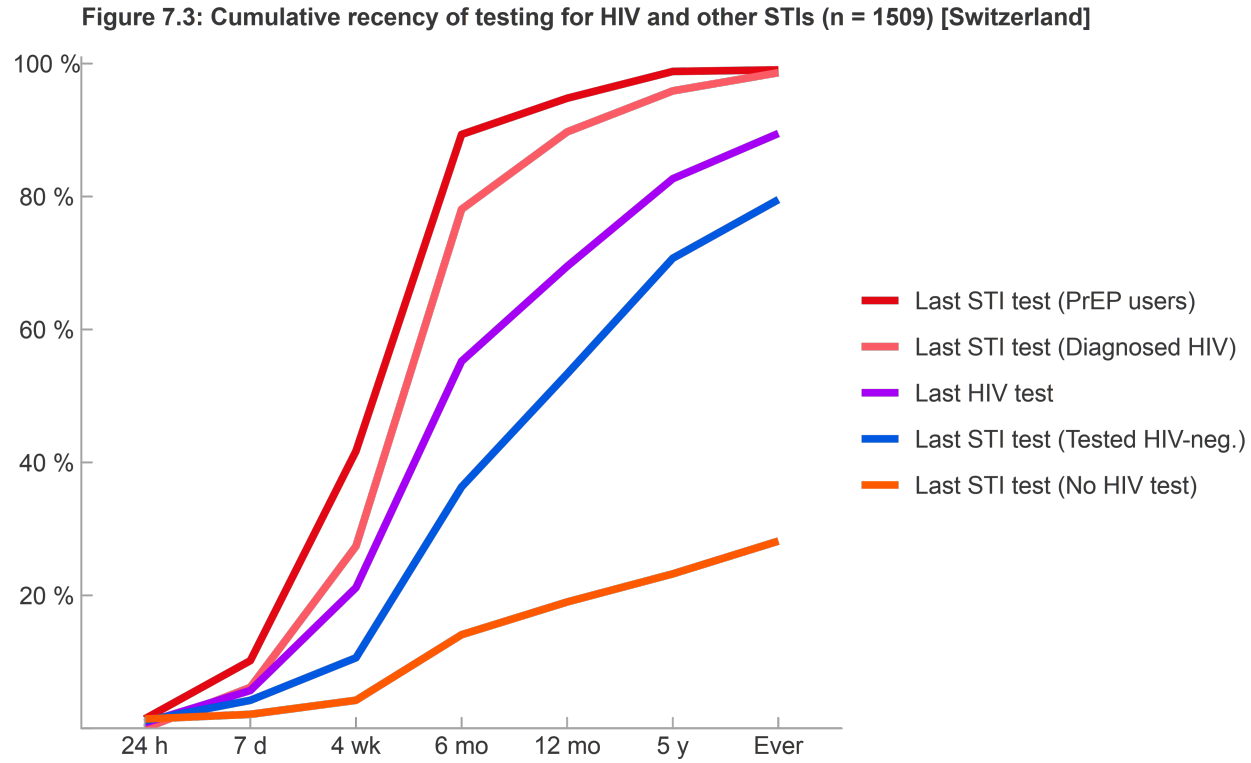
The recency of STI testing in these groups is then compared with the timing of the last HIV test among all respondents not already diagnosed with HIV (see **Section 7.5.1**).

Among PrEP users, 94.8 % had been tested for STIs in the previous 12 months, compared to 89.7 % of respondents with diagnosed HIV, and 53.3 % and 19 % among non-PrEP users who had previously tested for HIV or had never tested, respectively.

Although bacterial STIs such as syphilis, gonorrhoea, and chlamydia are more easily transmitted and less stigmatised than HIV, respondents without regular clinical follow-up (including PrEP users and people living with HIV) reported STI testing less often than HIV testing. Most clinical guidelines for HIV-positive MSM and PrEP users recommend routine blood tests for syphilis, which explains the higher testing rates in these

groups. However, many guidelines recommend syphilis screening every six months for all sexually active MSM [18].

Figure 7.3 Cumulative recency of testing for HIV and other STIs



Study participants who had an STI test in the previous 12 months were asked: *"Did you have any symptoms on that occasion?"* Overall, 84.7 % answered *"No"*, suggesting the test was part of routine screening; 14.5 % answered *"Yes"*, indicating that symptoms prompted them to seek healthcare; and 0.8 % responded *"I don't remember"* (N = 987, missing n = 1). Excluding those who did not remember, 85.4 % of respondents who had an STI test in the previous 12 months were asymptomatic at their last test. This suggests that most STI testing among MSM is driven by routine screening recommendations.

To better understand the impact of screening and partner notification on diagnoses, EMIS-2024 respondents diagnosed with gonorrhoea in the previous 12 months, as well as respondents diagnosed with chlamydia or *Lymphogranuloma venereum* (LGV), were asked: *"The last time you were diagnosed with [gonorrhoea/chlamydia], what was the reason for testing?"*.

Regarding diagnosed gonorrhoea, around one in three (37.4 %) reported having symptoms (pain, discharge, etc.), while 15.8 % were tested following partner notification, and 43.3 % had a routine check-up. Similarly, for diagnosed chlamydia, 27.5 %) reported symptoms, 12.7 % were notified by a partner with chlamydia, and 59.3 % had a routine check-up. had a routine check-up. These results reflect that gonorrhoea, particularly penile gonorrhoea, is more likely to cause noticeable symptoms.

7.6.3 Uptake of hepatitis C testing

Hepatitis C is rarely transmitted sexually, even among MSM [19]. For EMIS-2024, respondents were given the following information: *"While there is currently no vaccine available for hepatitis C, the good news is that most infections can be fully cured with daily medication taken over a period of 8 to 12 weeks. The majority of infections result from exposure to blood due to unsafe injection practices or due to sexual activities that can lead to blood exposure. It is recommended that individuals who engage in these practices undergo testing for hepatitis C."*

All study participants were then asked: *"When have you last been tested for hepatitis C?"*, with a scale to indicate how recently this had occurred. Overall, 40.2 % of respondents had been tested for hepatitis C within the previous 12 months.

Figure 7.4 shows testing recency for the same four groups presented earlier:

1. PrEP users, who in most European countries are recommended to have regular hepatitis C screening
2. Respondents with diagnosed HIV, who are recommended to be screened for hepatitis C every six months
3. Other respondents who have ever tested for HIV
4. Other respondents who have never tested for HIV

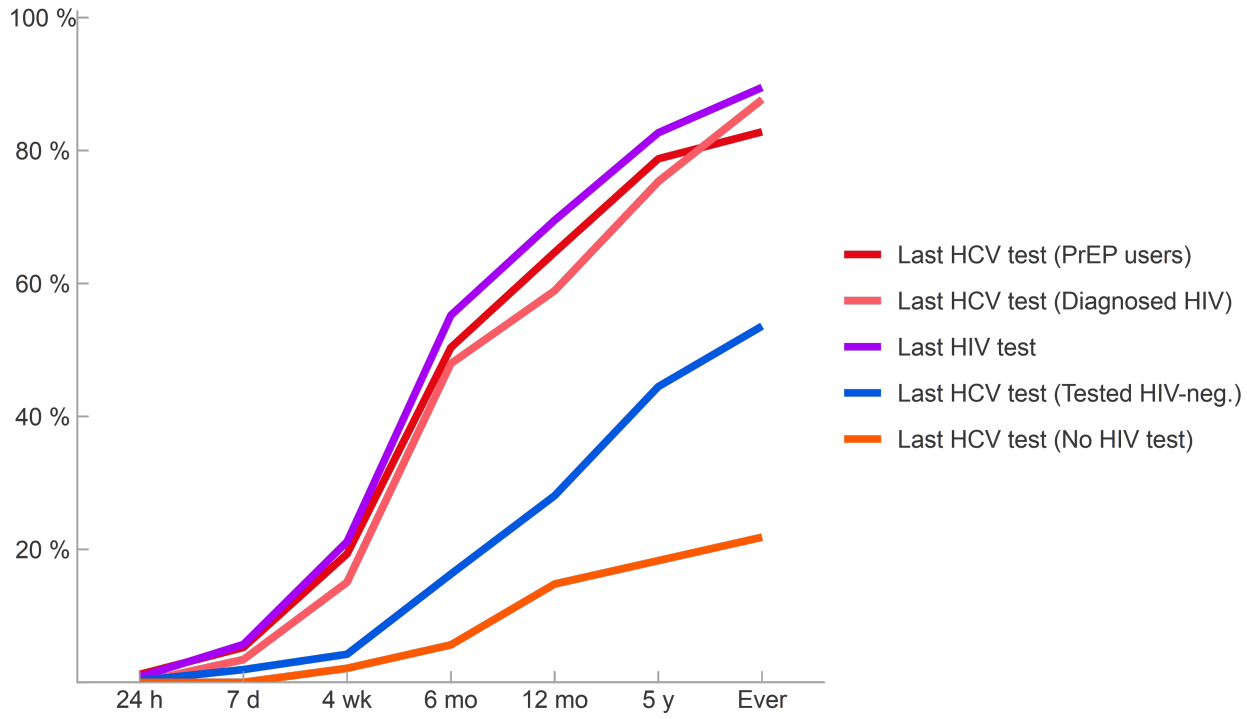
The recency of hepatitis C testing in these groups is also compared with the timing of the last HIV test among all respondents not already diagnosed with HIV (see **Section 7.5.1**).

Among PrEP users, 64.7 % had been tested for hepatitis C in the previous 12 months, compared with 58.9 % of respondents with diagnosed HIV, and 28.1 % and 14.8 % among non-PrEP users who had previously tested for HIV or had never tested, respectively.

Since hepatitis C is less easily transmitted sexually than HIV, respondents without regular clinical follow-up (PrEP users and people diagnosed with HIV) reported lower levels of hepatitis C testing than of HIV or STI testing. Most clinical guidelines for HIV-diagnosed MSM, and many guidelines for PrEP users, recommend routine blood tests for hepatitis C, which helps explain the comparatively higher testing rates in these groups.

Figure 7.4 Cumulative recency of testing for HIV and hepatitis C

Figure 7.4: Cumulative recency of testing for HIV and hepatitis C (n = 1504) [Switzerland]



7.6.4 Elements of STI testing

STI testing is not a single procedure but a combination of different components that vary according to a person's body, clinical guidelines, and local practice. Assessing which elements are included helps to understand the quality and completeness of testing across populations.

7.6.4.1 Genital STI testing

Study participants who had had an STI test in the previous 12 months were asked to respond to the following: *"So we can ask appropriate questions about STI tests, and because people's bodies differ, please let us know if you have… (Tick all that apply)"* with the options (depending on previous answers): a penis; a penis

(metoidioplasty); a penis (phalloplasty); a (neo)vagina; (neo)vulva with no vaginal depth (without vaginal opening). They were then asked a series of questions (appropriate to their morphology) about what elements of an STI screening they had experienced in the previous year. Unfortunately, due to a technical error, two questions used in the previous two EMIS waves were *not* shown to respondents: *"Have you provided a blood sample as part of any STI test in the last 12 months?"* and *"Have you provided a urine sample as part of any STI test in the last 12 months?"*. The remaining questions and responses are given in **Table 7.13**.

As described above, respondents were asked morphology-specific questions about elements of STI screening they had experienced in the previous year. Vaginal swabs are more sensitive for detecting genital gonorrhoea and chlamydia than urine samples. Among respondents with a vagina or related body parts (N = 28 who answered the question), 92.9 % reported having had a vaginal swab as part of STI testing in the past 12 months. In comparison, among respondents with a penis or related body parts (N = 942 who answered the question). 75.6 % reported a urethral swab as part of STI testing in the past 12 months.

However, due to a technical error, EMIS-2024 cannot report the overall proportion of respondents tested for genital STIs, as the question on providing a urine sample was omitted, regardless of body parts.

Table 7.13 Elements of STI testing experienced in the previous 12 months

Elements of STI screening experienced in the last 12 months	Urethral swab	Penis examination	Vaginal swab	Vagina examination	Anal swab	Anus examination
No	23.8	67.3	7.1	53.6	21.6	70.0
Yes	75.6	31.2	92.9	46.4	77.8	28.8
Not sure	0.6	1.5	0.0	0.0	0.5	1.2
Total	**100**	**100**	**100**	**100**	**100**	**100**

7.6.4.2 Anal swabbing

Following our EMIS-2010 and EMIS-2017 publications on the performance of STI screening services for gay and bisexual men across European cities [20,21], we recommended including an indicator for comprehensive STI testing in the ECDC monitoring framework. A full STI screen was defined as having reported the following tests in the previous 12 months: an HIV test (unless already diagnosed with HIV), a blood test for other STIs, an anal swab, and either a urethral/meatal or vaginal swab or a urine sample. However, due to the loss of two questions caused by a technical error, this indicator can no longer be constructed.

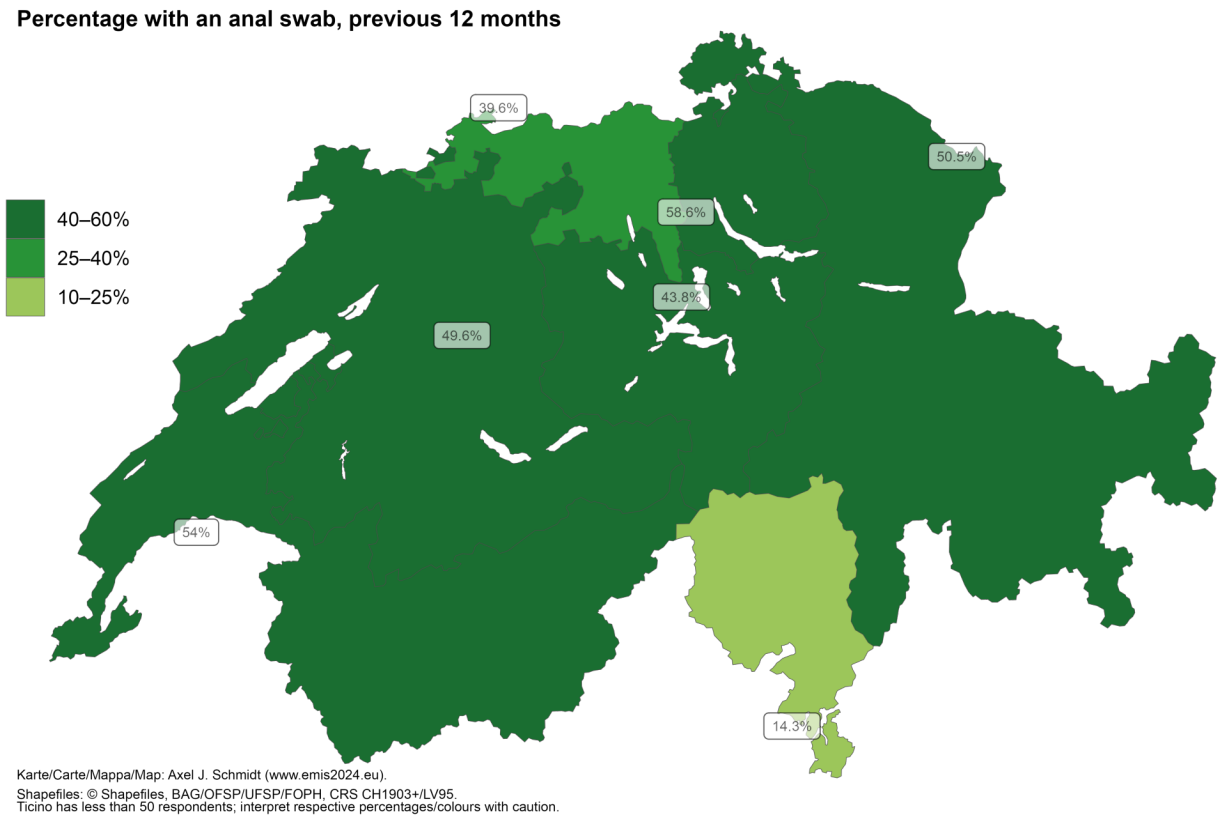
Whether full STI screens for gonorrhoea and chlamydia provide a public health benefit remains under debate, with recent research suggesting they may not [22–25]. These debates, however, do not affect the continued need to screen MSM for syphilis. Syphilis testing is blood-based rather than reliant on anal, genital, or pharyngeal swabs, and in previous EMIS rounds it was almost universally included in STI testing [20,21]. In EMIS-2017, blood testing for STIs—primarily syphilis—was included in 92.2 % of all reported STI tests [26].

Between 2010 and 2017, the use of anal swabbing increased markedly across European cities [21]. Shortly after the completion of EMIS-2024 fieldwork, Belgium and the Netherlands issued new guidelines that discontinued routine asymptomatic screening—even for MSM—despite the fact that asymptomatic infections among MSM occur most frequently in the oropharynx and rectum/anus where they often don't cause symptoms [27].

In EMIS-2017, across Europe, anal swabbing was performed in 37.1% of all reported STI tests conducted in the previous 12 months [26]. By EMIS-2024, this proportion had increased to 77.8 % in Switzerland — although sampling bias cannot be ruled out as a possible explanation for differences in the crude proportions. If this substantial increase is not entirely a sampling artefact, it could largely explain the recently observed rises in diagnosed gonorrhoea and chlamydia in Europe [23,28] and Switzerland [29].

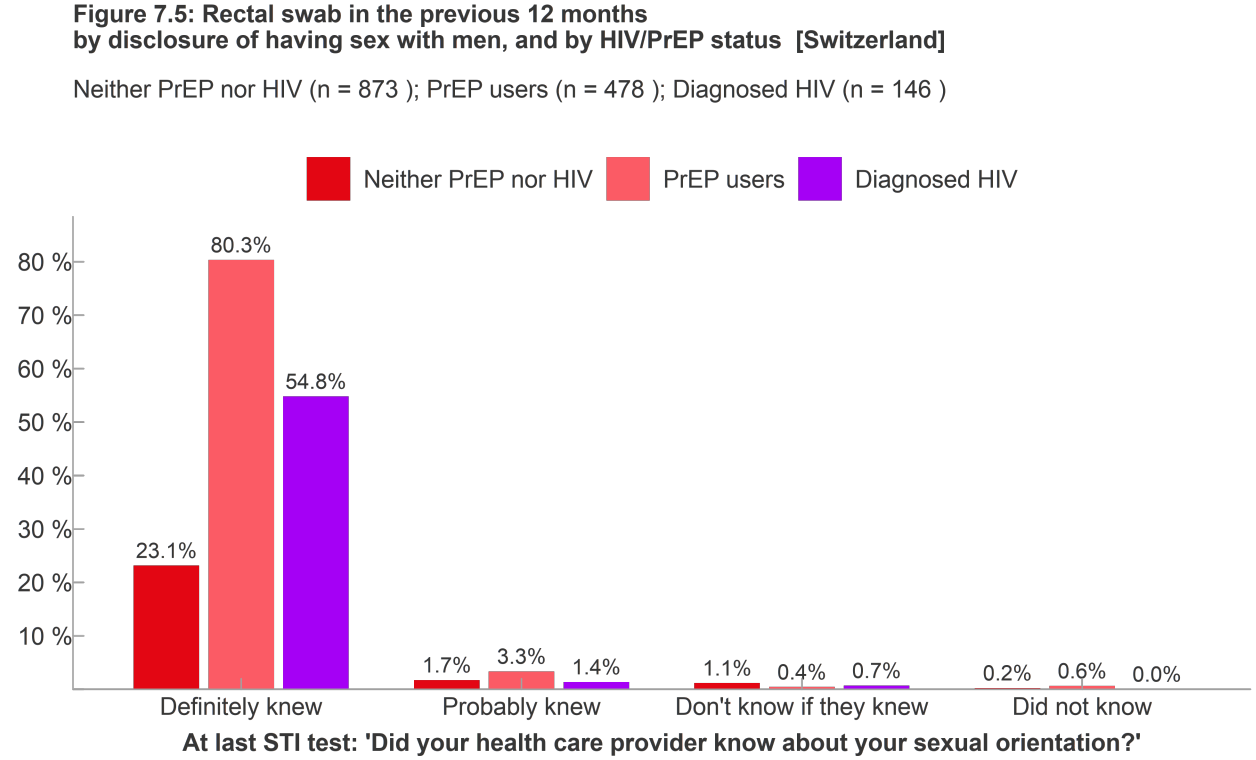
The previous figures refer to the proportion of STI tests that included an anal swab. In contrast, **Map 7.8** presents a respondent-based measure: the proportion of all respondents (regardless of whether they reported an STI test) who reported undergoing an anal swab in the past 12 months, thereby highlighting considerable variation across Switzerland.

Map 7.8 Percentage receiving anal swabbing as part of STI testing, previous 12 months



Having received anal swabbing in the past 12 months was associated with disclosure of having sex with men, as well as with PrEP use or being in clinical care for HIV. Clinical guidelines in 2024 recommended anal swabbing for all PrEP users: 80.3 % of PrEP users received a full STI screen in the past 12 months when their provider knew they had sex with men, vs. 0.6 when they did not. Among respondents not using PrEP (and not being diagnosed with HIV), anal swabbing was reported by 23.1 % vs. 0.2 %.

Figure 7.5 Anal swabbing as part of STI testing, by disclosure of sex with men (basis: all respondents with an STI screen in the previous 12 months)



7.6.4.3 Genital and anal physical examinations

Among respondents with a vagina or related body parts (N = 28 who answered the question)—none of whom were cisgender women—a vaginal physical examination, which is standard practice in gynaecology, was reported by 46.4 %.

By comparison, among respondents with a penis or related body parts (N = 599 who answered the question), 31.2 % reported having undergone a physical examination of the penis (**Table 7.13**).

In contrast, anal examinations—typically carried out to detect anal warts or non-transmissible conditions such as fissures—were the least frequently reported element of STI testing. Only around one in three (28.8 %) respondents indicated having had such an examination (N = 982). This low prevalence reflects a shift in clinical practice: as anal self-swabbing has increasingly replaced physician-performed swabbing, comprehensive anal physical examinations are becoming uncommon and, in many settings, are now the exception rather than the rule.

Anal fissures are a fairly common anorectal condition, and they can occur among anally receptive men, particularly those with less experience. Traumatic injury to the anal canal (for example, from stretching, friction, or passing large or hard objects) is implicated in fissure development.

7.6.5 Partner notification for diagnosed gonorrhoea

Partner notification is a key element of STI control, enabling early diagnosis and treatment to prevent onward transmission. Examining how often and under what circumstances partners are informed provides insight into both individual behaviour and the role of healthcare providers in supporting this process.

Study participants who had been diagnosed with gonorrhoea in the 12 months were asked: *“The last time you were diagnosed with gonorrhoea, did you (or your healthcare provider) inform your recent sexual partners that they also needed a test/treatment?”* An identical question was asked of respondents diagnosed with syphilis in the previous 12 months, however, due to a technical mistake, this question was lost.

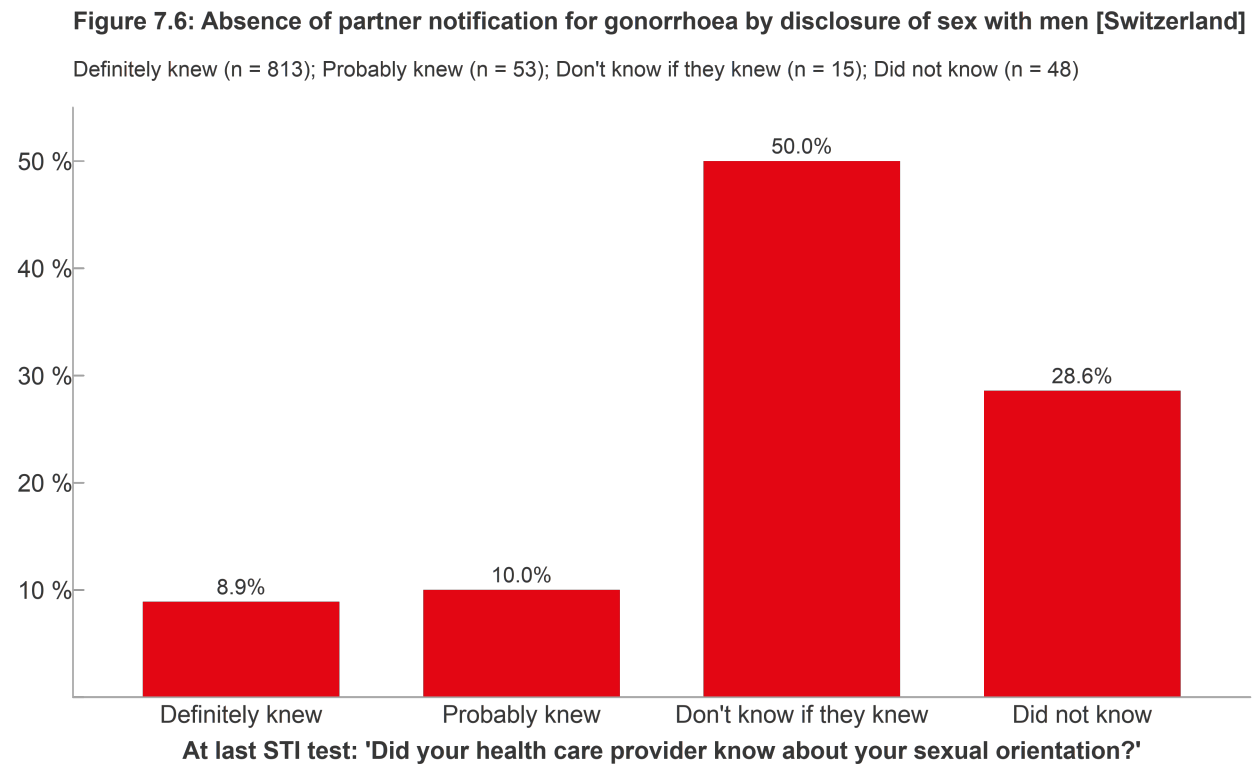
Table 7.14 The last time you were diagnosed with gonorrhoea did you (or your healthcare provider) inform your recent sexual partners that they also needed a test/treatment?

Partner notification at last syphilis or gonorrhea diagnosis	% of respondents diagnosed with syphilis/gonorrhoea
No, none of them	9.4
Yes, some of them	47.3
Yes, all of them	42.4
I don't remember	1.0
Total	**100**

Almost all (89.7 %) diagnosed with gonorrhoea informed at least some of their sexual partners that they needed to seek a test or treatment.

Partner notification was associated with disclosure of having sex with men. Among respondents undergoing STI testing who were sure the healthcare provider knew they had sex with men, 8.9 % did not notify their sex partners regarding their diagnosis of gonorrhoea, compared to 28.6 % who said their healthcare provider did not know. Thus, taking a sexual history might have a direct impact on onward transmission of STIs.

Figure 7.6 Absence of partner notification for gonorrhoea as a function of disclosure of sex with men at last STI test



7.7 Treatment interventions

Access to and uptake of treatment is a cornerstone of effective sexual health interventions. This section examines treatment for STIs, viral hepatitis, and HIV, with attention to adherence to guidelines and progress towards international goals.

7.7.1 STI treatment

STI treatment uptake was nearly universal. Among respondents diagnosed with syphilis or gonorrhoea, 96.8 % and 99.5 %, respectively, reported having received treatment. Focusing on gonorrhoea, for which all European guidelines recommend at least intravenous or intramuscular Ceftriaxone as part of treatment, around one in six respondents (17.2 %) reported being treated only with pills. A further 16.7 % received both pills and an injection, while 65.5 % were treated with an injection alone.

7.7.2 Treatment for Hepatitis B and C

Chronic viral hepatitis remains a major health concern, but effective treatment can prevent long-term complications and onward transmission. Here we assess access to specialist care for hepatitis B and reported clearance of hepatitis C following treatment.

There are less than two respondents with chronic hepatitis B in the EMIS-2024 subsample for Switzerland, hence treatment uptake cannot be calculated.

Similarly, among the 23 respondents ever diagnosed with hepatitis C, 56.5 % reported that their infection had been cleared with treatment.

7.7.3 HIV monitoring and treatment: cascade of care

Successful HIV treatment requires both consistent clinical monitoring and access to antiretroviral therapy. Analysing the HIV care cascade provides insight into how many people with diagnosed HIV are linked to, retained in, and benefitting from care.

Study participants with diagnosed HIV (9.8 % of all respondents, see **Chapter 3**) were asked, *"When did you last see a health professional for monitoring your HIV infection?"*, and were offered a scale to indicate how recently this had occurred. **Table 7.11** shows the responses.

Table 7.11 Recency of seeing a health professional to monitor HIV infection (among respondents with diagnosed HIV)

Recency of HIV monitoring by a health professional	Respondents diagnosed with HIV	Cumulative %
Within the last 24 hours		
Within the last 7 days	11.6	11.6
Within the last 4 weeks	32.2	43.8
Within the last 6 months	56.2	100.0
Within the last 12 months		
Within the last 5 years		
More than 5 years ago		
Never		
Total	**100.0**	

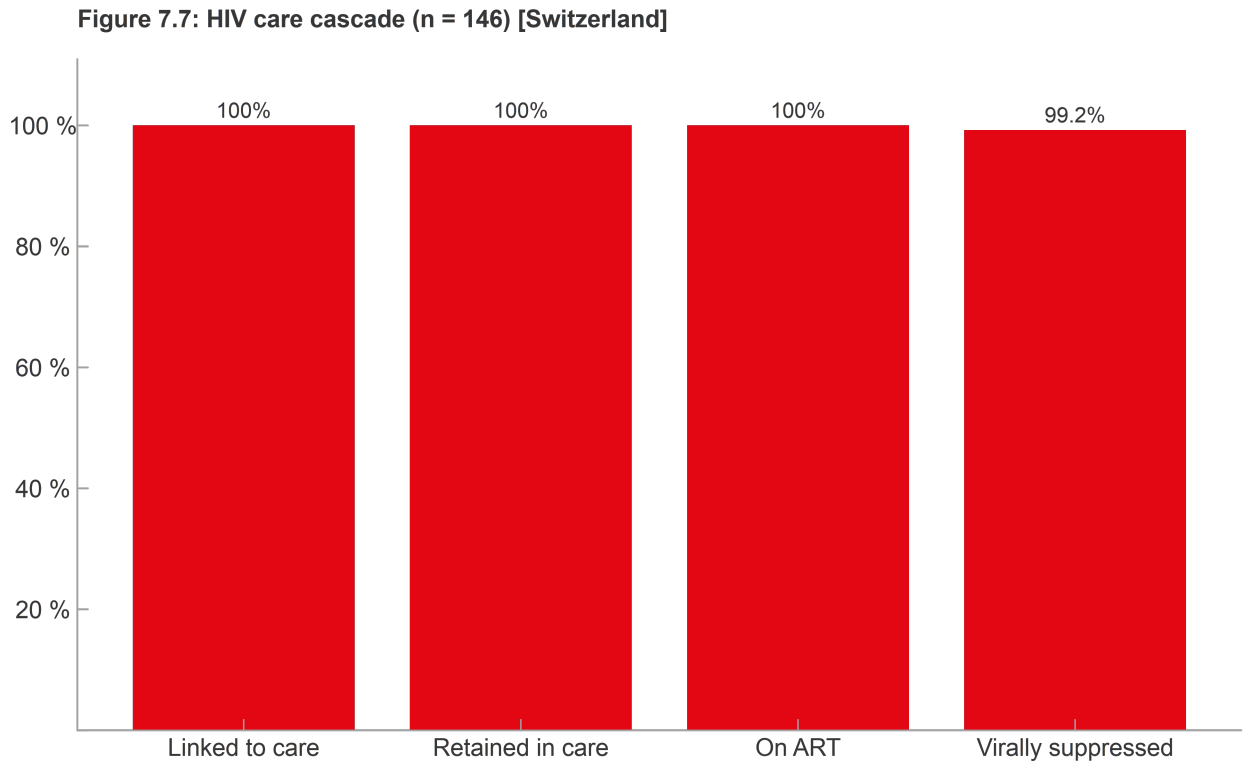
In Switzerland, measurement of HIV-RNA is recommended every 3–6 months, with higher frequencies at treatment initiation [30]. Accordingly, the vast majority (100 %) were monitored within the previous six months.

For the construction of ECDC monitoring indicators related to HIV care, we defined ever having an HIV infection monitored as **linked to care** (HIV care cascade stage 3), and having an HIV infection monitored in the past six months (or receiving ART) as **retained in care** (HIV care cascade stage 4). Measuring the proportion of HIV-diagnosed MSM linked to and retained in care is challenging using clinical data, such as HIV cohort studies [31]. According to the above definition, across Switzerland, 100 % were linked to care, and 100 % were retained in care. The difference between the **retained in care** indicator and monitoring within the last six months is due to the receipt of antiretroviral treatment, as in some settings viral load measurements are conducted less frequently than every six months.

As for the subsequent two stages of the HIV care cascade, 100 % of HIV-diagnosed respondents were **receiving ART** (HIV care cascade stage 5, see **Chapter 5**), and 99.2 % of HIV-diagnosed respondents had **undetectable viral load** (HIV care cascade stage 6). The latter also corresponds to 99.2 % of respondents receiving antiretroviral treatment.

Among HIV-diagnosed EMIS-2024 study participants in Switzerland, the second (on ART) and third (virally suppressed) of UNAIDS' three 95-95-95 goals—corresponding to 90.2% of those with diagnosed HIV achieving viral suppression—were reached in 2024.

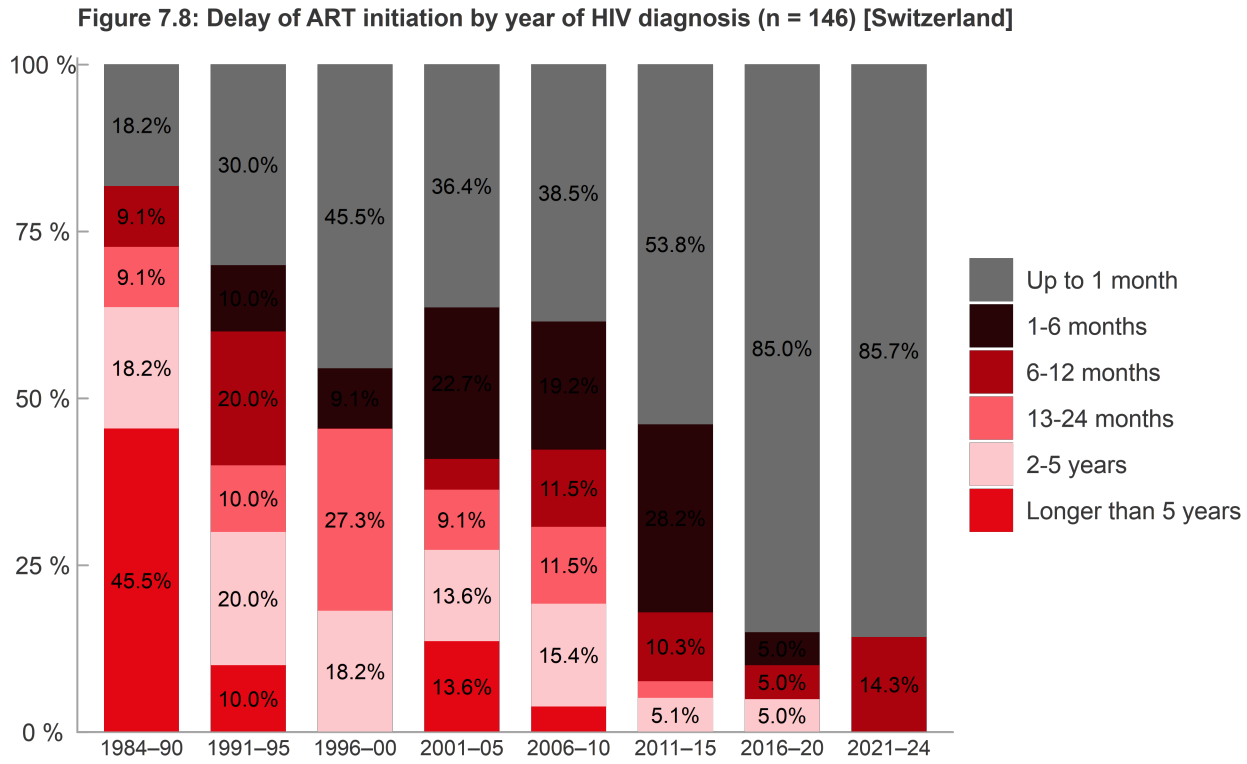
Figure 7.7 Clinical stages of the HIV care cascade



7.7.4 Timing of ART initiation

Prompt initiation of antiretroviral therapy (ART) after an HIV diagnosis is critical for both individual health and reducing onward transmission. **Figure 7.8** illustrates how the interval between diagnosis and starting ART has changed over time, highlighting the temporary adoption of the 'Hit hard and early' strategy in 1996 and the overall trend towards progressively earlier treatment initiation.

Figure 7.8 Delay of ART initiation by year of HIV diagnosis (N = 146)



7.7.5 Involuntary interruption of antiretroviral treatment (ART)

Around the turn of 2023 to 2024, some people in Europe using antiretroviral treatment (ART) for HIV experienced interruptions in their medication. These disruptions arose from a range of factors, including difficulties in accessing health services during the COVID-19 pandemic, but were primarily driven by global shortages of antiretrovirals caused by challenges in production, packaging, and transport logistics, alongside other personal or structural barriers to consistent use.

Understanding the frequency and reasons for such interruptions is important for assessing gaps in the HIV cascade of care and ensuring equitable access to ART.

In EMIS-2024, all participants taking ART were asked: *"When was the last time you experienced an involuntary interruption of your anti-HIV medication?"* Almost all respondents (94.7 %) reported "Never", while the remainder indicated experiencing interruptions in the past. Around one in 50 respondents (2.3 %) reported an involuntary interruption of their life-saving medication around 2023/24. Reports of interruptions in other years were less frequent and varied by country. The much lower proportion of involuntary ART interruptions contrasts sharply with the experience of involuntary PrEP interruptions.

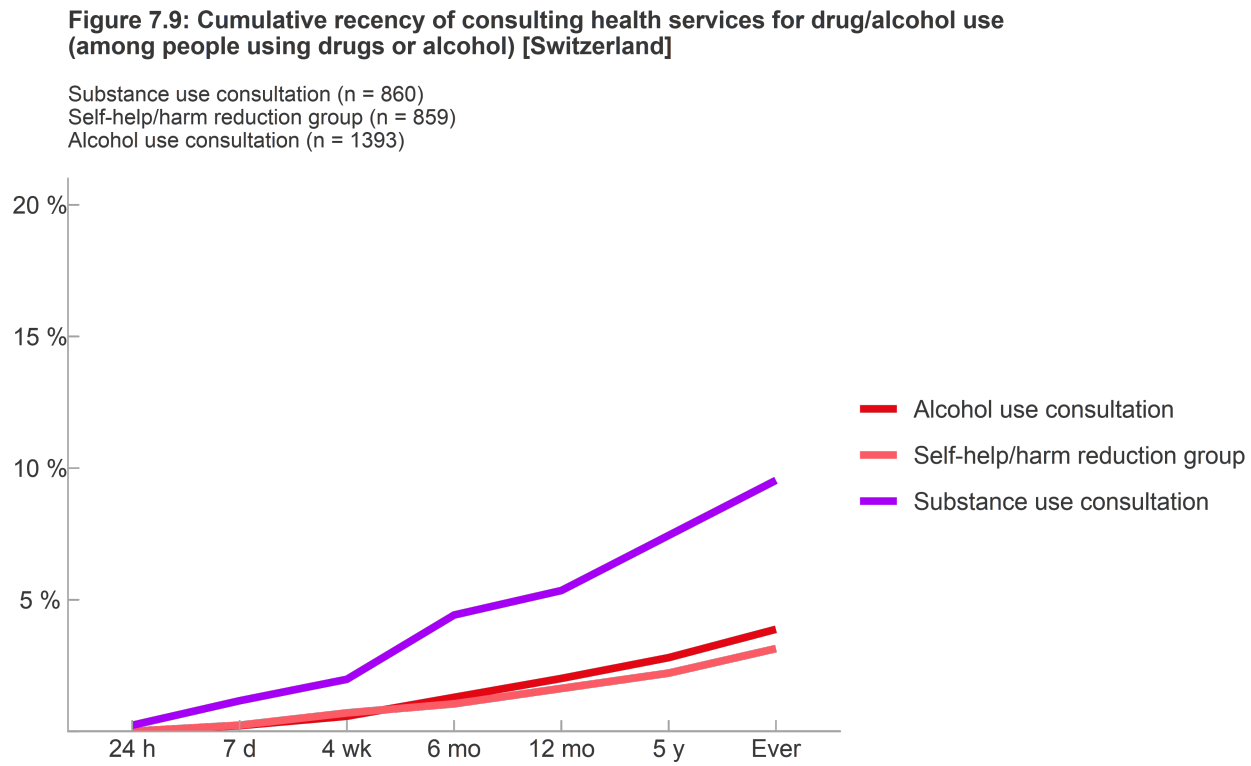
7.8 Substance use service

Substance use services—such as counselling, one-to-one therapy, and group session—can support individuals in managing their drug use, including progressing towards abstinence. Respondents who reported any substance or alcohol use, regardless of the level of consumption, were asked three questions about their use of substance use services:

- *"Have you ever consulted a health professional for your alcohol use concerns?"*
- *"Have you ever consulted a health professional for your drug use concerns (apart from tobacco use)?"*
- *"Have you ever attended a self-help group, harm reduction programme or counsellor about your drug us (apart from tobacco use)?"*

For each statement, study participants were offered a scale to indicate how recently this had occurred. The cumulative percentages for having done these three things within each period are shown in **Figure 7.8** which also shows the percentage for each response.

Figure 7.9 Cumulative recency of consulting health services for drug/alcohol use concerns



Overall, in the previous 12 months, slightly more respondents had consulted a health professional regarding drug use (5.3 %) than for alcohol use concerns (2 %). Among respondents who had used illicit drugs (including cannabis) in the past 12 months, around one in 50 (1.6 %) reported consulting a self-help group or harm reduction programme or counsellor about drug use (apart from tobacco use).

7.9 Regional variation in interventions

Table 7.15 Regional variation in key interventions

Qualifying cases	Switzerland	% saw or heard MSM-specific information about HIV or STIs *	% offered hepatitis vaccination by health service **	% with full course of HAV vaccination	% with full course of HBV vaccination	% with at least one shot of HPV vaccine	% with at least one shot of mpox vaccine
1 509	**Overall Total**	**91.6**	**73.9**	**69.3**	**72.1**	**20.6**	**32.8**
	Regions						
313	Région lémanique	91.4	74.8	62.5	67	27.5	34.6
266	Espace Mittelland	95.1	72.6	70.8	72.9	19.5	27.3
197	Nordwestschweiz	91.4	72.1	70.4	71.6	15.2	27.4
486	Zürich	90.9	75.1	74	75.3	21.8	41.9
107	Ostschweiz	90.7	72.9	64.4	71.2	18.7	26.7
89	Zentralschweiz	(89.9)	(73)	(69.8)	(73.6)	(11.2)	(19.1)
35	Ticino	(85.7)	(74.3)	(59.4)	(71.9)	(11.4)	(17.1)
	Cities						
262	Zürich	93.1	79.8	78.5	78.5	28.2	52.5
157	Geneva-Lausanne	91.7	77.7	66	67.1	36.9	45.5

Numbers in parentheses ( ) indicate that the total number of respondents for that category is less than 100 (N < 100).
Numbers in brackets [ ] indicate that the total number of respondents is less than 20 (N < 20). * last 12 months; ** ever

Table 7.15 Regional variation in key interventions (continued)

Qualifying cases	Switzerland	% spoken to about PrEP at a health service	% tested for HIV *	% using community HIV-testing at last HIV test	% using HIV self-sampling at last HIV test	% using HIV self-testing at last HIV test	% tested for STIs *	% receiving anal swabbing *
1 509	**Overall Total**	**49.7**	**69.9**	**42.3**	**1.3**	**3.5**	**65.8**	**51**
	Regions							
313	Région lémanique	53.8	74.7	49.8	1.8	3.5	71.2	54
266	Espace Mittelland	54.9	65.1	41.5	0.4	2.5	65.8	49.6
197	Nordwestschweiz	36.7	62.7	37.3	1.7	5.6	54.3	39.6
486	Zürich	53.8	76.2	44	1.3	3.1	71.2	58.6
107	Ostschweiz	42.7	68.9	(32.3)	(1)	(4.2)	62.6	50.5
89	Zentralschweiz	(45.7)	(62.2)	(41)	(1.2)	(1.2)	(55.1)	(43.8)
35	Ticino	(23.3)	(40)	(17.2)	(0)	(6.9)	(42.9)	(14.3)
	Cities							
262	Zürich	63.7	81.2	43	1.2	3.6	78.6	66.8
157	Geneva-Lausanne	61.2	78.4	51	2.1	2.1	76.4	61.1

Numbers in parentheses ( ) indicate that the total number of respondents for that category is less than 100 (N < 100).
Numbers in brackets [ ] indicate that the total number of respondents is less than 20 (N < 20).

* last 12 months

Table 7.15 Regional variation in key interventions (continued)

Qualifying cases	Switzerland	% notifying sexual partners for diagnosed gonorrhoea	% retained in care (HIV care cascade stage 3)	% on ART (HIV care cascade stage 5)	% virally suppressed (HIV care cascade stage 6)	% with substance use counselling / self-support group
1 509	**Overall Total**	**89.7**	**100**	**100**	**99.2**	**1.6**
	Regions					
313	Région lémanique	(89.5)	(100)	(100)	(100)	1.1
266	Espace Mittelland	(90.9)	(100)	(100)	(100)	1.4
197	Nordwestschweiz	(82.6)	[100]	[100]	[100]	0
486	Zürich	(90.5)	(100)	(100)	(98.1)	1.9
107	Ostschweiz	[100]	[100]	[100]	[100]	(3.2)
89	Zentralschweiz	[85.7]	[100]	[100]	[100]	(5.1)
35	Ticino	[100]	[100]	[100]	[100]	[0]
	Cities			(100)		
262	Zürich	(88.9)	(100)	(100)	[98.1]	2.4
157	Geneva-Lausanne	(88.6)	[100]	[100]	[100]	2

Numbers in parentheses ( ) indicate that the total number of respondents for that category is less than 100 (N < 100).
Numbers in brackets [ ] indicate that the total number of respondents is less than 20 (N < 20).

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Chapter 8: Trans community

This chapter provides data on our variables among the sub-sample of transgender and non-binary respondents. We identified four subgroups:

5. Transgender men, who indicated “Man” as gender identity and “Female” as sex assigned at birth;
6. Transgender women, who indicated “Woman” as gender identity and “Male” as sex assigned at birth;
7. AFAB non-binary people, who indicated “Non-binary” as gender identity and “Female” as sex assigned at birth;
8. AMAB non-binary people, who indicated “Non-binary” as gender identity and “Male” as sex assigned at birth [1].

We took the choice of dividing non-binary people in these last two subgroups in order to better understand and report on topics which greatly differ based on sex assigned at birth (*e.g.* morbidities and behaviours) [2].

The needs and behaviours of transgender and non-binary people may be different than those of cisgender MSM, and some of our variables investigated issues specific to this community. These are:

(a) Gender-affirming care,

(b) Transphobic discrimination,

(c) Transphobic abuse, and

(d) Transgender community perception.

Therefore, we discuss in this chapter the relevant binary indicators among transgender and non-binary people.

We provide data for the four groups on total of 90 health indicators:

- 16 demographics indicators,
- 17 morbidity indicators,
- 27 behaviour indicators,
- 12 needs indicators, and
- 18 intervention indicators.

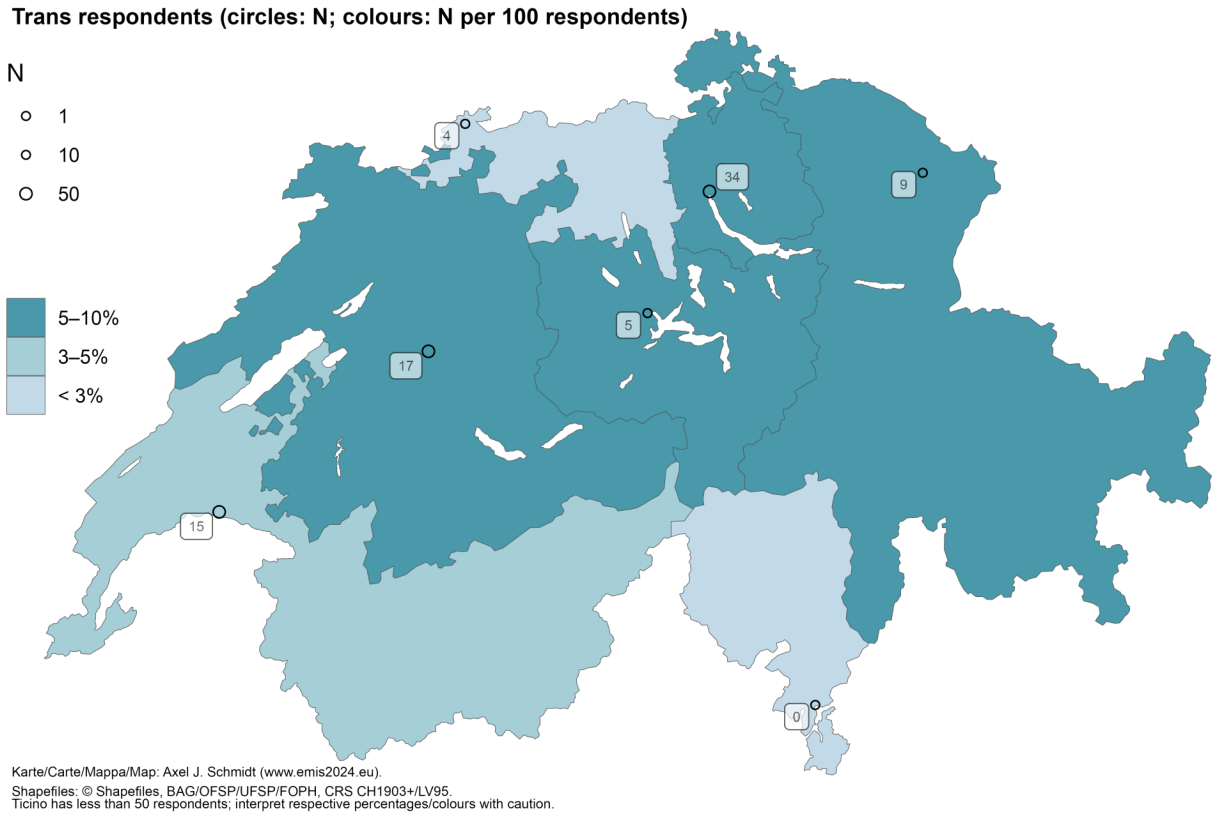
8.1 Demographics

The variables reported in this paragraph relate to characteristics of the study participants and their situation that health promotion programmes cannot change or are usually not trying to change. In other words, there is no “preferred” response to the questions although some programmes may have outcome targets related to these characteristics.

From the perspective of sexual health promotion, the characteristics reported in this paragraph sometimes describe a target group for interventions (*e.g.* transgender women).

Map 8.1 shows the distribution of the recruitment rates across Switzerland of trans and non-binary people who identify as part of the trans community.

Map 8.1: Recruitment of trans and non-binary people (who identify as part of the trans community) (N = 113)

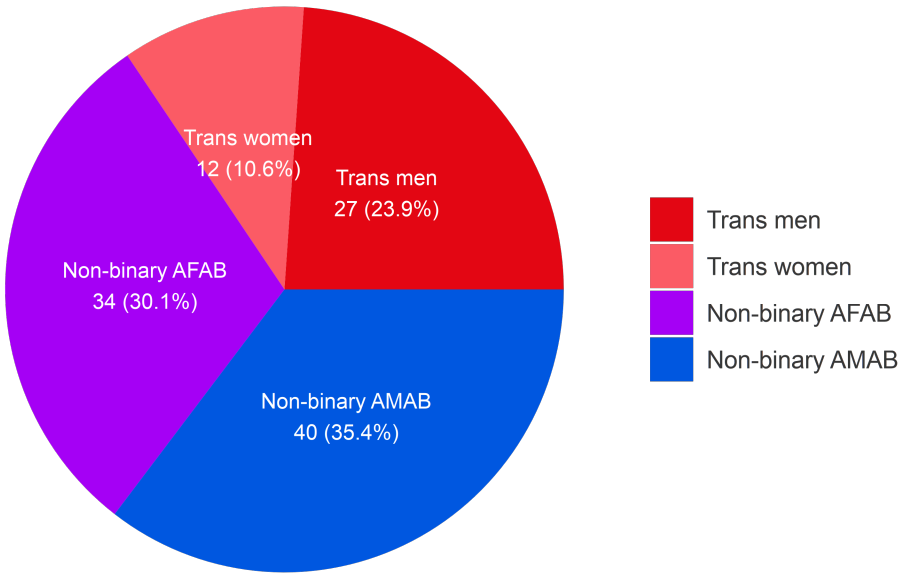


8.1.1 Trans and non-binary subgroups

This chapter described the demographic characteristics of 113 respondents: 27 transgender men, 12 transgender women, 34 AFAB non-binary people, and 40 AMAB non-binary people resident in 50 countries.

Figure 8.1: Number of trans and non-binary respondents

Figure 8.1: Number of trans and non-binary respondents (n = 113) [Switzerland]



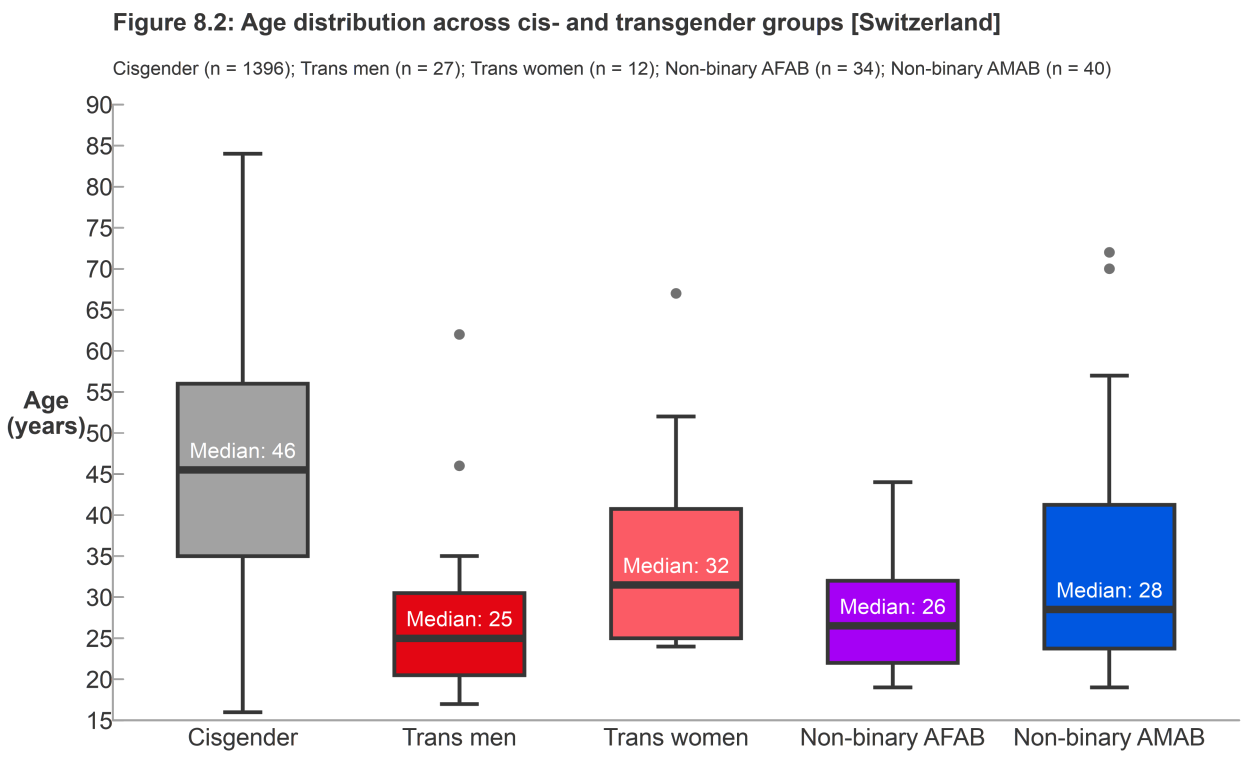
All study participants were asked: *"What is your current gender identity?"* and were offered the responses *"Man"*; *"Woman"*; *"Non-binary"*. Then, they were asked: *"What sex were you assigned at birth?"* and offered the responses: *"Male"* or *"Female"*. Respondents who indicated a discordance between sex assigned at birth and gender identity (*e.g.* those who did not indicate *"Man-Male"* or *"Woman-Female"*) were presented the following: *"You have selected that your gender differs from your sex assigned at birth. Do you identify as part of the trans community?"* and offered responses *"Yes"*; *"No"*; *"I don't know"*. Respondents who selected *"Man"* as gender identity but *"Female"* as sex assigned at birth were categorised as *"Trans Men"*. Respondents who selected *"Woman"* as gender identity but *"Male"* as sex assigned at birth were categorised as *"Trans Women"*. Respondents who selected *"Non-binary"* as gender identity were distinguished between *Non-binary AFAB* (if they selected *"Female"* as sex assigned at birth) and *Non-binary AMAB* (if they selected *"Male"* as sex assigned at birth).

The transgender and non-binary sample was constituted mostly by trans men (23.9 %) and Non-binary AMAB respondents (35.4 %). 30.1 % were Non-binary AFAB people, and 10.6 % were trans women.

8.1.2 Age

On average, trans and non-binary respondents had a median age of 27 years (IQR: 23–34).

Figure 8.2: Age distribution across cis- and transgender groups



The median age of the transgender sample was 27, much younger than the cisgender sample (median age 46 years). Trans women and non-binary AMAB respondents were older on average (median age 29 and 32 years), and trans men represented the youngest group (median age 25 years).

8.1.3 Migrancy

All study participants were asked: *"Were you born in <Country Living In>?"* and were offered the responses *"Yes"* or *"No"*. Overall, 23 % indicated that they were not born in the country they currently lived in. All study participants were asked: *"Which country were you born in?"* and offered a list of countries. **Table 8.1** summarises responses recorded into continents (both of those who were and who were not born in the country they live in).

Table 8.1: Migration History

Country of birth recoded to continents*	% of trans men	% of trans women	% of non-binary AFAB	% of non-binary AMAB
Europe n = 106	96.3	100	94.1	90.0
South America n = 0	3.7	0	0.0	2.5
North America (and Caribbean) n = 2	0.0	0	2.9	2.5
Asia n = 2	0.0	0	2.9	2.5
Africa n = 1	0.0	0	0.0	2.5
Total n = 2	**100**	**100**	**100**	**100**

* Missing n = 0

The majority of trans and non-binary respondents (93.8 %) were born in a European country.

All study participants not born in the country they lived in were asked: *"Why did you come to <country living in>?"* and were provided the responses in **Table 8.2**.

Table 8.2: Reason for migration

Reason for migration* N = 26	% of trans men	% of trans women	% of non-binary AFAB	% of non-binary AMAB	% of all
I was brought as a child	19.2	0.0	7.7	11.5	38.5
To study	7.7	3.8	11.5	0.0	23.1
To work	15.4	0.0	11.5	11.5	38.5
To be with a partner	3.8	3.8	7.7	11.5	26.9
To live more openly as gay/bisexual/trans/queer	3.8	0.0	7.7	3.8	15.4
To seek asylum	0.0	0.0	7.7	0.0	7.7
I came as a refugee	0.0	0.0	7.7	0.0	7.7
I was brought against my will	3.8	0.0	0.0	0.0	3.8
Other answer	0.0	0.0	0.0	0.0	0.0

* Missing n = 0

Work (n = 10, 38.5 %) and study (n = 6, 23.1 %) were the most commonly cited reason for migration, shortly followed by the argument of being able to live more openly as gay/bisexual/trans/queer (n = 4, 15.4 %) and being brought as a child (n = 10, 38.5 %).

Of the respondents not born in the country they live in, (n = 2, 7.7 %) indicated that they migrated to seek asylum, and (n = 2, 7.7 %) came as a refugee.

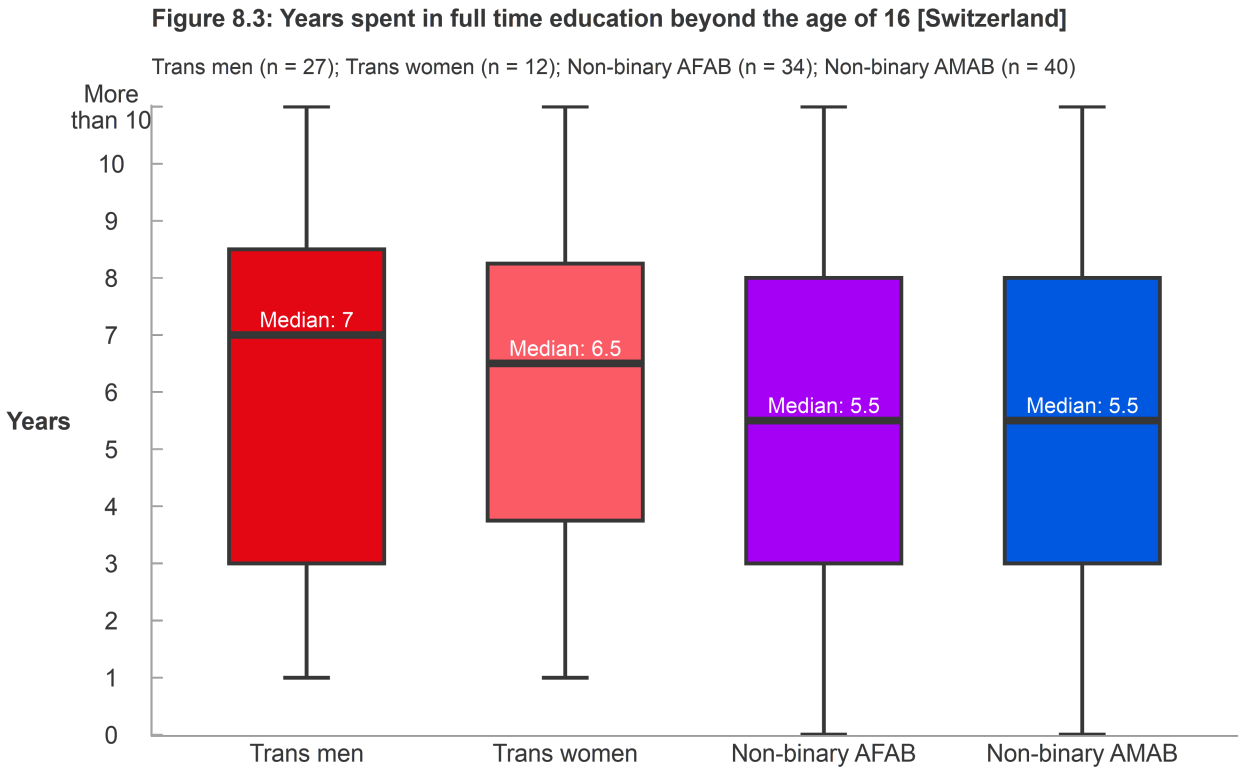
8.1.4 Education

All study participants were asked: *"How many years have you spent in full-time education since the age of 16?"*.

The median number of years in education was 6, which was consistent for every subgroup except trans men (median age 7 years). The vast majority (96.5 %) had some education after the age of 16, and 88.5 % had more than two years in full-time education after the age of 16.

Figure 8.3 shows the distribution of education after the age of 16 years. There is an OECD document that guides how to convert post-16 education into ISCED-1997 degrees at the national level [3].

Figure 8.3: Years spent in full–time education beyond the age of 16



Then, study participants were asked: *"Which of the following best describes your current occupation?"*, and we offered the responses in **Table 8.3**.

Table 8.3: Current occupation/work status

Current occupation* N = 113	% of trans men	% of trans women	% of non-binary AFAB	% of non-binary AMAB	% of all
Employed full-time	18.5	41.7	17.6	30.0	24.8
Employed part-time	22.2	41.7	35.3	30.0	31.0
Self-employed	3.7	0.0	2.9	7.5	4.4
Student	51.9	8.3	29.4	25.0	31.0
Other	3.7	0.0	2.9	0.0	1.8
Retired	0.0	8.3	0.0	5.0	2.7
Unemployed	0.0	0.0	2.9	0.0	0.9
Long-term sick leave / medically retired	0.0	0.0	8.8	2.5	3.5

* Missing n = 0

Most of trans and non-binary respondents were either still students (31 %) or in full-time employment (24.8 %) and 0.9 % were unemployed.

8.1.5 Financial coping

All study participants were asked: *"Which of these phrases would you say comes closest to your feelings about your income these days?"* and were offered the responses in **Table 8.4**.

Table 8.4: Self-perceptions of financial status

Self-perceptions of financial status* N = 113	% of trans men	% of trans women	% of non-binary AFAB	% of non-binary AMAB	% of all
Really comfortable	14.8	0.0	5.9	5.0	7.1
Comfortable	25.9	16.7	20.6	35.0	26.5
Neither comfortable nor struggling	40.7	41.7	44.1	40.0	41.6
Struggling	7.4	41.7	20.6	12.5	16.8
Really struggling	11.1	0.0	8.8	7.5	8.0

* Missing n = 0

While overall 24.8 % were struggling financially, among those 26.5 % were in long-term sick leave or medically retired and 25.7 % were unemployed. A total of 33.6 % were feeling comfortable with their current income.

8.1.6 Sexual Orientation

All study participants were asked: *"Which of the following options best describes how you think of yourself with respect to your sexuality?"* and were offered the responses shown in **Table 8.5**. Around one in three of the sample identified as *bisexual* (30.1 %), and around one in four as *gay/lesbian or homosexual* (24.8 %).

While the label *"gay/lesbian or homosexual"* was more common for transgender men (44.4 %) and non-binary people who were assigned male at birth (27.5 %), only one in 28 of non-binary people assigned female at birth (3.5 %) and even fewer (0.9 %) transgender women preferred that term. However, only 1.8 % identified as *straight*, with the majority being transgender women (26.5 % of the sample).

Around one in four trans and non-binary respondents preferred *any other term* not included in the list (27.4 %), and 15.9 % *do not use any term*.

Table 8.5: Sexual orientation

Sexual orientation* N = 113	% of trans men	% of trans women	% of non-binary AFAB	% of non-binary AMAB	Total
Gay/Lesbian or homosexual	44.4	8.3	11.8	27.5	24.8
Bisexual	22.2	75.0	23.5	27.5	30.1
Any other term	14.8	0.0	38.2	35.0	27.4
I don't usually use a term	18.5	0.0	26.5	10.0	15.9
Straight or heterosexual	0.0	16.7	0.0	0.0	1.8
Total	**100**	**100**	**100**	**100**	**100**

* Missing n = 0

8.1.7 Partnership status

All study participants were asked: *"Do you currently have a 'steady partner', that is a lover or spouse, that means you are not 'single'?"* and were offered the responses: *"No, I am single"*; *"Yes, I have a steady partner"*; *"I'm not sure/it's complicated"*.

Respondents who indicated that they have a steady partner were then asked: *"Are you currently in a relationship with…? (Tick as many as apply)"* and offered the responses: *"One man"*; *"More than one man"*; *"One non-binary person"*; *"More than one non-binary person"*; *"One woman"*; *"More than one woman"*.

Table 8.6: Percentages with a current "steady partner" and type of partnership

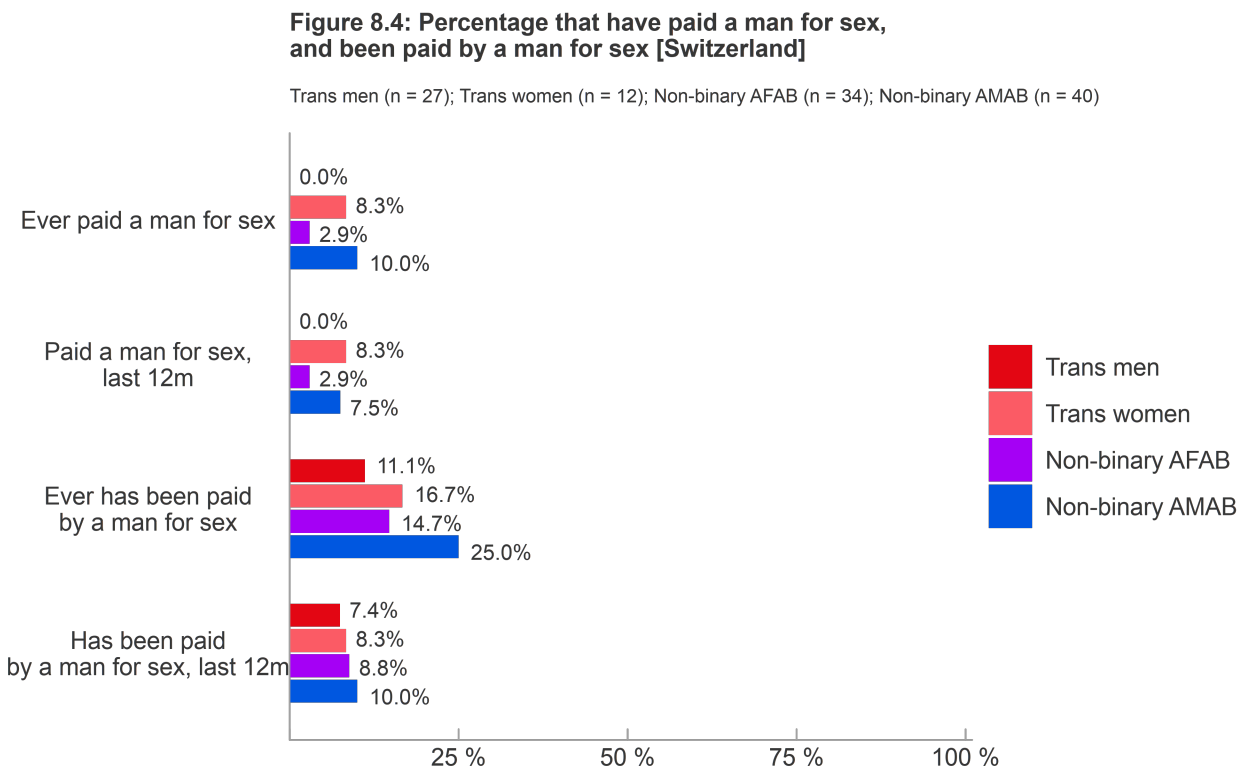
Type of Partnership*		Current Partnership**	
	%		%
Single	45.1		
In a relationship with a steady partner	41.6	One man	53.2
		More than one man	4.3
		One non-binary person	17.0
		More than one non-binary person	8.5
		One woman	34.0
		More than one woman	0.0
Complicated	13.3		
Total	**100**		

* Missing n = 0; ** Missing n = 0

8.1.8 Sex work

All study participants were asked: *"When was the last time you paid a man to have sex with you?" (By paid we mean you gave him money, gifts or favours in return for sex)* and *"When was the last time you were paid by a man to have sex with him?" (By paid we mean he gave you money, gifts or favours in return for sex)* and each question offered a scale to indicate how recently this had occurred. **Figure 8.4** shows the percentage that have paid a man for sex or been paid by a man for sex among the transgender groups.

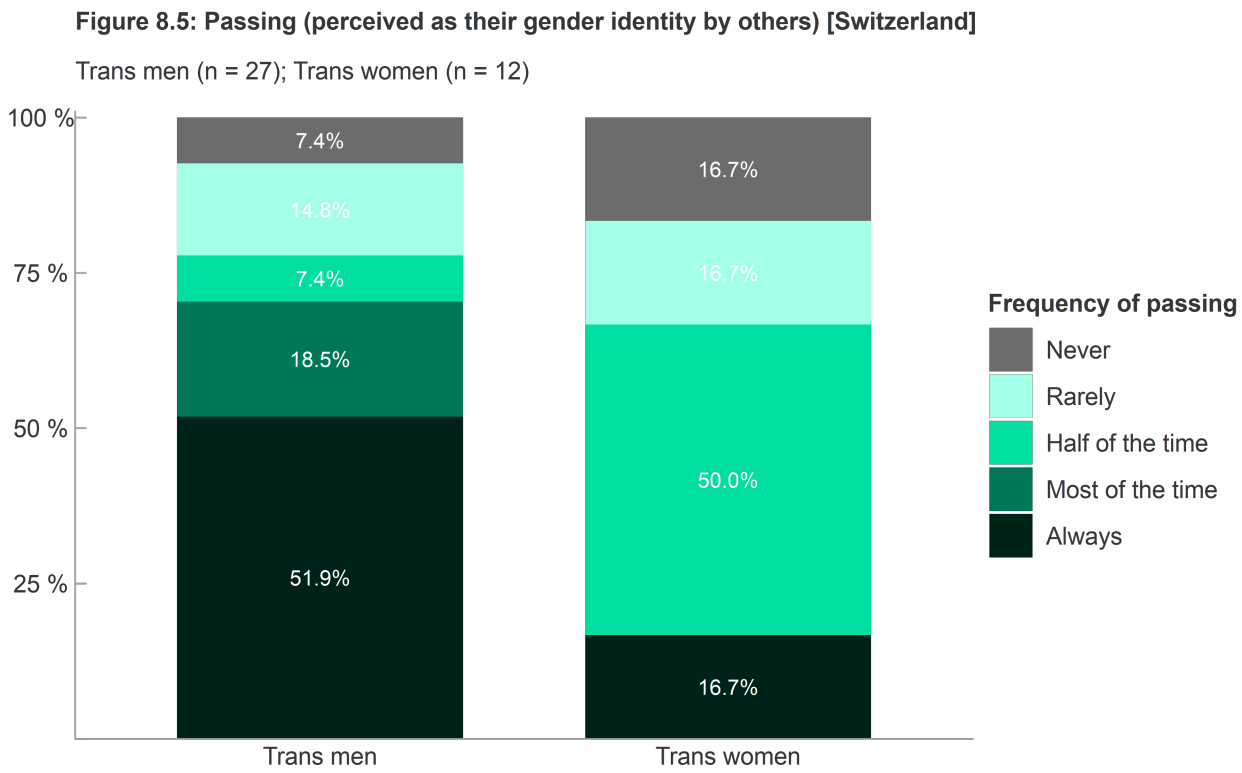
Figure 8.4: Percentage that have paid a man for sex, and been paid by a man for sex



More transgender and non-binary people had been paid for sex rather than paying someone else, both in their lifetime (17.7% versus 5.3 %) and in the last 12 months (8.8% versus 4.4 %). This observation was consistent for all subgroups, but there were striking differences in the number of trans and non-binary respondents buying/selling sex among the four groups. Trans women were most likely to have been paid by a man

for sex, both in their lifetime (16.7 %) and in the last 12 months (8.3 %). Around one in eleven (25 %) of non-binary AMAB respondents had ever been paid by a man for sex, in contrast to 11.1 % trans men and 14.7 % non-binary AFAB individuals. Moreover, non-binary AMAB respondents were most likely to had *ever* paid a man for sex, both in their lifetime (10 %) and *last 12 months* (7.5 %). Around one in 100 of trans women (8.3 %) had *ever* paid a man for sex, around one in Inf of trans men (0 %) and non-binary AFAB individuals (2.9 %).

Figure 8.5: Passing



Most trans men (70.4 %) report passing at least more than half of the time, while most trans women don't pass more than half of the time (83.3 %).

8.2 Morbidities

Morbidities include both physical and psychological ill health. For a health programme, reduction in and prevention of morbidities are the ultimate outcomes sought. EMIS-2024 asked about two areas of sexual health morbidity: **mental health** and **sexually transmitted infections**.

8.2.1 Mental health

Transgender and non-binary people generally face worse mental health outcomes compared to cisgender people [4,5]. They experience higher rates of psychological distress, and they are more likely to receive a mental health diagnosis, such as depression or anxiety. Additionally, they are at a greater risk for suicidal ideation compared to the general population [6–8] .

8.2.1.1 Anxiety/depression

In our survey, we used the Patient Health Questionnaire [9], a short clinical screening tool that measures combined anxiety and depression, to give an indication of mental well-being. While the tool is not intended to be diagnostic, and may overestimate the prevalence of problems, it was chosen for its brevity and ease of interpretation.

All study participants were asked: *"Over the last 2 weeks, how often have you been bothered by the following problems?"* and were offered the following four items: *"Feeling nervous, anxious, or on edge"*; *"Not being able to stop or control worrying"*, *"Little interest or pleasure in doing things"*, *"Feeling down, depressed, or hopeless"*. Responses to each item included *"Not at all"* (0 points); *"Some days"* (1 point); *"More than half the days"* (2 points); *"Nearly every day"* (3 points). The total points give a score from 0 to 12, which can be grouped into four bands. **Table 8.7** gives the percentage of trans and non-binary respondents falling in each band and the usual interpretation for this validated scale.

Table 8.7: Anxiety and depression (PHQ-4) score

PHQ-4 score	Interpretation	n*	% overall	% of trans men	% of trans women	% of non-binary AFAB	% of non-binary AMAB
0–2	Normal	19	16.8	22.2	16.7	2.9	25.0
3–5	Mild anxiety and depression	47	41.6	44.4	50.0	35.3	42.5
6–8	Moderate anxiety and depression	27	23.9	25.9	8.3	32.4	20.0
9–12	Severe anxiety and depression	20	17.7	7.4	25.0	29.4	12.5
Total		**113**	**100**	**100**	**100**	**100**	**100**

* Missing n = 0

Overall, 41.6 % reported at least moderate anxiety and depression in the last two weeks, with one in six trans and non-binary respondents (17.7 %) experiencing severe anxiety and depression in the same time period.

8.2.1.2 Suicidal ideation

Study participants were asked: *"Over the last 2 weeks, how often have you been bothered by the following problems?"* and were presented with the two statements below. Responses included *"Nearly every day"*; *"More than half the days"*; *"Some days"*; and *"Not at all"*. **Table 8.8** shows the percentages of suicidal ideation over the last two weeks, among the four transgender groups. The final column provides the percentage for the total population.

Table 8.8: Suicidal ideation over the last two weeks

Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead, or of hurting yourself in some way?	% of trans men	% of trans women	% of non-binary AFAB	% of non-binary AMAB	% of all
Not at all	63.0	75.0	50.0	62.5	60.2
Some day	29.6	8.3	38.2	27.5	29.2
More than half	3.7	8.3	8.8	5.0	6.2
Everyday	3.7	8.3	2.9	5.0	4.4
Total	**100**	**100**	**100**	**100**	**100**

Missing n = 0

Over the last 2 weeks, how often have you been bothered by thoughts about taking your own life?	% of trans men	% of trans women	% of non-binary AFAB	% of non-binary AMAB	% of all
Not at all	88.9	75.0	73.5	70.0	76.1
Some day	11.1	16.7	17.6	20.0	16.8
More than half	0.0	8.3	5.9	5.0	4.4
Everyday	0.0	0.0	2.9	5.0	2.7
Total	**100**	**100**	**100**	**100**	**100**

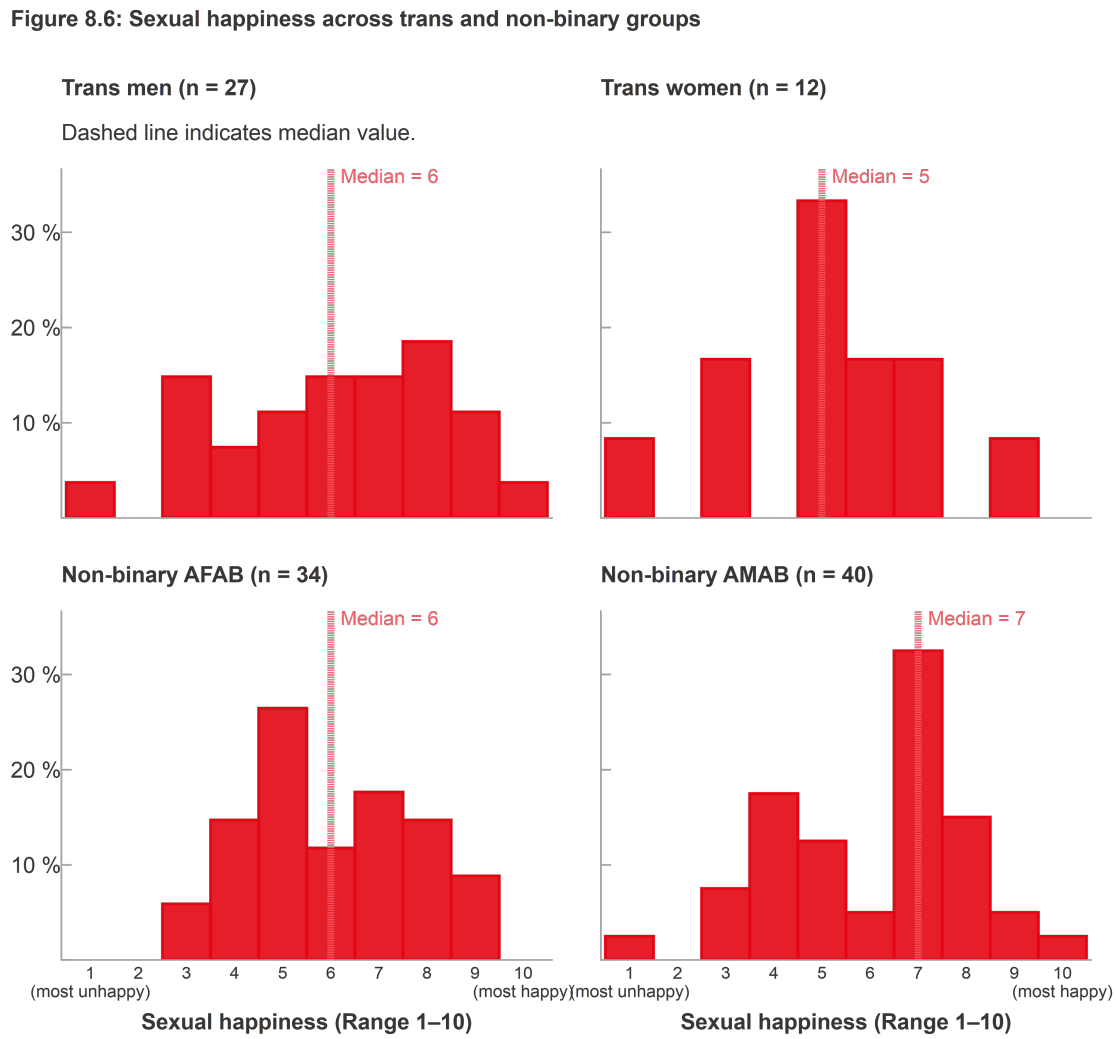
Missing n = 0

Overall, 39.8 % trans and non-binary respondents had thought of harming themselves in the past two weeks and 23.9 % had been bothered by thoughts of taking their own life.

8.2.1.3 Sexual un(happiness)

Study 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?"* and were offered a ten-point scale labelled at the ends *(1–most unhappy to 10–most happy)*.

Figure 8.6: Sexual happiness self-rating across transgender groups



Overall, 24.8 % of trans and non-binary respondents gave a score of 4 or below, indicating unhappiness with their sexual life, with a median score of 6.

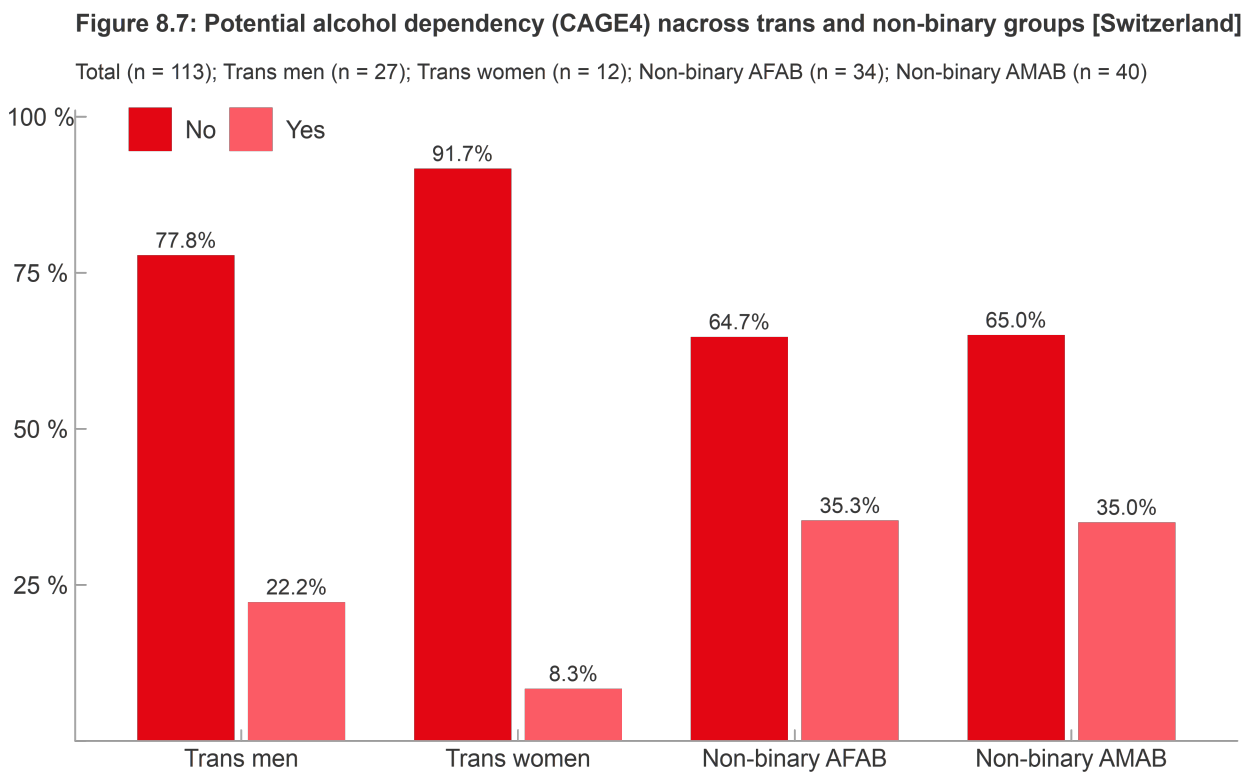
8.2.1.4 Alcohol dependency (CAGE4)

We used the CAGE4 screening tool for alcohol dependency [10]. While the tool is not intended to be diagnostic and may over-estimate the prevalence of problems, it was chosen for its brevity and ease of interpretation. Study participants were asked: *"Thinking about drinking alcohol in the past 12 months…"* followed by four questions to which they could respond *"Yes"* or *"No"*:

- *"Have you tried to cut down on your drinking?"*
- *"Have people annoyed you by criticising your drinking?"*
- *"Have you felt bad or guilty about your drinking?"*
- *"Have you taken a drink first thing in the morning to steady your nerves or get rid of a hangover?"*

Indicating *"Yes" to two or more statements* is a positive response, indicating possible *alcohol dependency*.

Figure 8.7: Potential alcohol dependency (CAGE4) across transgender groups



Overall, 29.2 % met the criteria for potential alcohol dependency.

8.2.2 HIV and other STI diagnosis

Diagnosed HIV

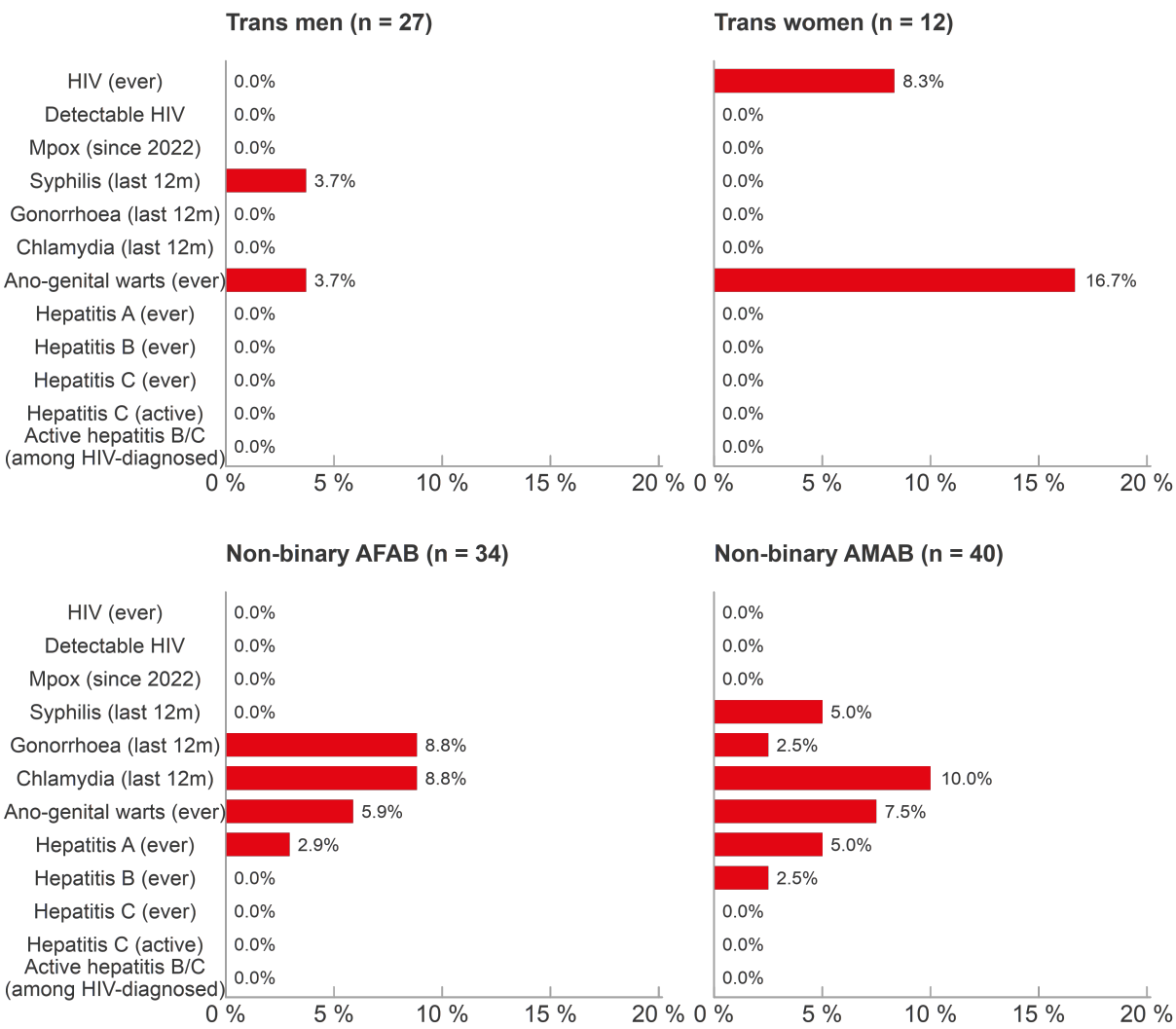
Study participants were asked: *"Have you ever been diagnosed with HIV?"* 0.9 % of trans and non-binary respondents selected *"Yes"*.

Out of the trans and non-binary respondents who were diagnosed with HIV, 100 % were transgender women, 0 % were non-binary AMAB individuals, 0 % were transgender men, and 0 % were AFAB non-binary persons.

STI diagnoses

All study participants were asked: *"Have you ever been diagnosed with Syphilis?"* and identical questions were asked for *"Gonorrhoea"*, *"Chlamydia or LGV"*, *"anal or genital warts"*, and *"Hepatitis C"*. Study participants were also asked: *"Have you been vaccinated against hepatitis A?"* (with an identical question asked about hepatitis B) and *"Have you had mpox ('monkeypox') since 2022?"*. **Figure 8.9** summarises the presence of HIV and other STIs in the transgender sample.

Figure 8.9: Experience of HIV, selected STIs, and viral hepatitis



8.3 Behaviour

This chapter reports on all respondents' behaviours. We asked about two types of risk behaviour (having sex, taking drugs and doing them together) and four types of precaution behaviour (taking antiretroviral drugs, sharing HIV status information, using condoms, and being vaccinated).

8.3.1 Taking HIV treatment with HIV

Overall, 0.9 % (N = 1) indicated they had been diagnosed with HIV.

For people diagnosed with HIV, taking anti-retroviral treatment (ART) can result in undetectable levels of viral load which equates to a non-infectious state [11,12]. Taking HIV treatment is therefore a type of precautionary behaviour to prevent HIV transmission for people with HIV.

8.3.1.1 Prevalence of HIV antiretroviral treatment taking

All respondents who had ever been diagnosed with HIV were asked: *"Have you ever taken antiretroviral treatment (sometimes known as ART or HAART) for your HIV infection?"* (N = 1) and among those who had ever taken ART were asked: *"Are you currently taking antiretroviral treatment?"* (N = 1).

The percentages giving each response are set out in **Table 8.9**, among the trans groups.

Table 8.9: Taking ART with diagnosed HIV

ART*	% of trans men	% of trans women	% of non-binary AFAB
Taking ART n = 1	0	100	0
Currently taking n = 1	0	100	0

* Ever taken antiretroviral treatment: Missing n = 0; currently taking antiretroviral treatment: Missing n = 0

Among the trans and non-binary respondents with diagnosed HIV, 100 % (n = 1, missing n = 0) knew they had ever taken ART, or 100 % excluding those who did not know whether they had taken ART (n =1). Overall, 100 % (1/1) of respondents with diagnosed HIV indicated they were currently taking ART, or 100 % (1/ 1 excluding those who did not know or did not answer.

8.3.2 PrEP Use

All study participants were asked: *"Have you ever tried to get PrEP?"* and offered the responses in **Table 8.10**.

Table 8.10: Taking PrEP

Ever taken PrEP* N = 112	% of trans men	% of trans women	% of non-binary AFAB	% of non-binary AMAB	% of all
No	92.6	100	91.2	67.5	83.9
Yes, on a daily basis and I'm still taking it	7.4	0	5.9	10.0	7.1
Yes, on a daily basis but I'm no longer taking it	0.0	0	2.9	7.5	3.6
Yes, when I have needed it but not daily	0.0	0	0.0	15.0	5.4
Total	**100**	**100**	**100**	**100**	**100**

* Missing n = 0

A total of 16.1 % trans and non-binary respondents indicated *"Ever"* of having taken PrEP, with 44.4 % of them currently using it. Non-binary AMAB individuals were the trans group with the largest PrEP uptake, making up 72.2 % of PrEP users in the transgender sample.

8.3.3 PEP use

Respondents who had never been diagnosed with HIV and those who had never tested were asked: *"Have you ever taken PEP?"* and offered the responses in **Table 8.11**.

Table 8.11: Taking PEP

Taking PEP* N = 112	% of trans men	% of trans women	% of non-binary AFAB	% of non-binary AMAB	% of all
No, I never felt the need to take it	96.3	90.9	82.4	80.0	85.7
No, I could not get it	3.7	9.1	2.9	5.0	4.5
No, I had the opportunity but decided not to take it	0.0	0.0	8.8	2.5	3.6
Yes, I've taken one course of pills	0.0	0.0	5.9	7.5	4.5
Yes, I've taken more than one course of pills	0.0	0.0	0.0	5.0	1.8

* Missing n = 0

Overall, 6.2 % of trans and non-binary respondents had ever taken PEP, 1.8 % had taken more than one course of PEP, and 4.5 % had wanted to get PEP, but could not get it. Out of the people who could not get PEP, 20 % Trans women and 40 % of non-binary AMAB respondents had the biggest difficulty.

8.3.4 Sexual Repertoire

Respondents who reported sex with non-steady partners were asked: *"Thinking about the sex you've had with non-steady male partners only, how long has it been since you engaged in each of the following? (please say when you last did something, even if this was not typical for you)"*, with the response options:

(12)mutual masturbation,

(13)sucking a man's penis,

(14)get one's penis sucked,

(15)lick a man's anus,

(16)have a man lick one's anus,

(17)have "active" anal intercourse,

(18)have "passive" anal intercourse,

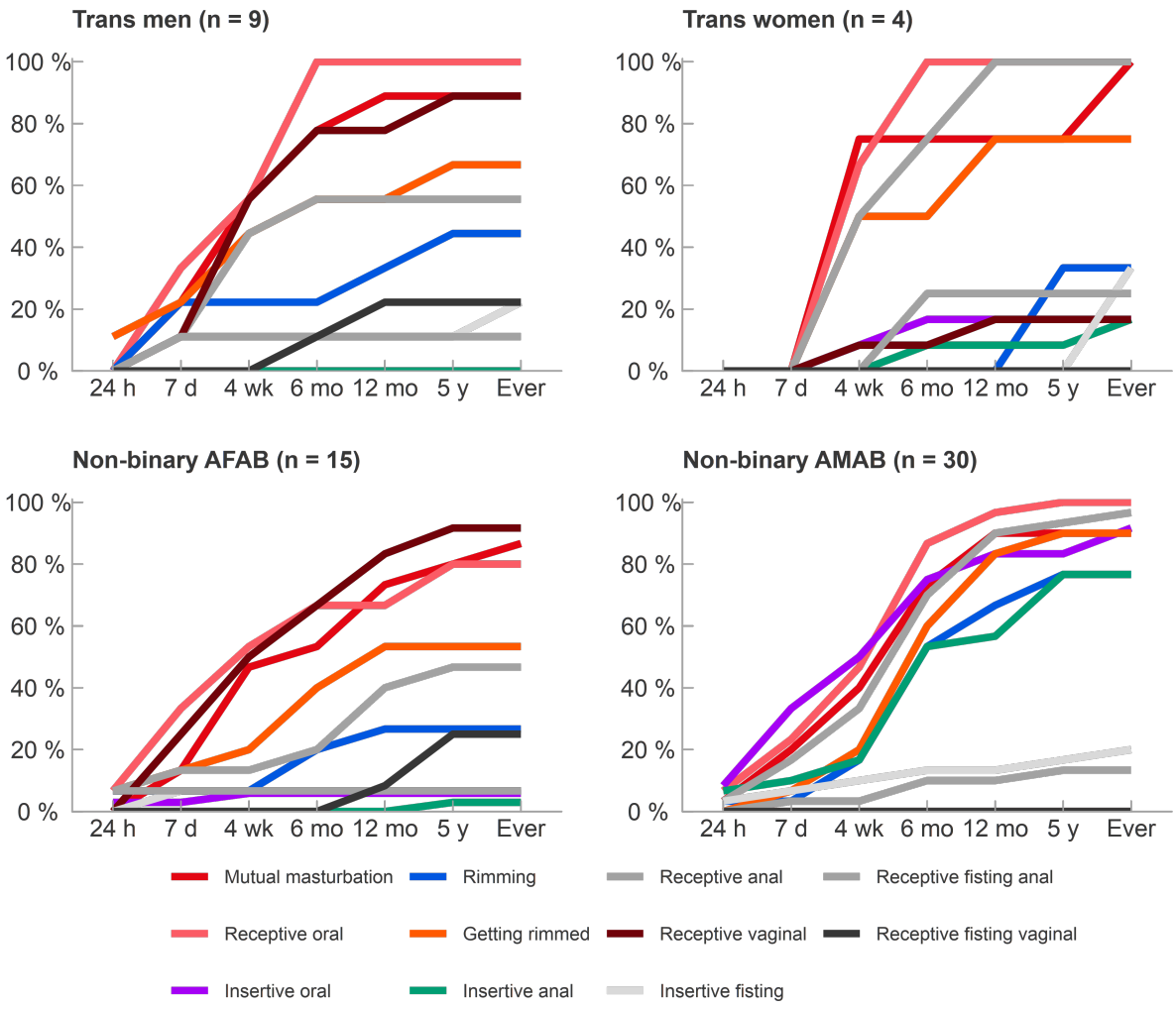
(19)put one's hand in a man's rectum,

(20)have a man's hand in one's rectum.

The recency of the different behaviours is shown as a recency curve in **Figure 8.10**.

Anal intercourse had the highest recency, followed by rimming ,oral sex , fisting and mutual masturbation had the lowest recency.

Figure 8.10: Cumulative recency of sexual practices with non-steady male partner among trans and non-binary people



For all subgroups, receptive oral sex was the most common sexual practice (94.7 % had ever engaged in receptive oral sex). For trans men and non-binary AFAB respondents, receptive vaginal sex was the second most common practice (88.9 %) of trans men and 91.7 % of non-binary AFAB respondents had receptive vaginal sex). One in two of trans men (55.6 %) and non-binary AFAB respondents (46.7 %) had instead engaged in receptive anal sex. The second most common practice was receptive anal sex for trans women (100 % of trans women had receptive anal sex), and insertive oral sex for non-binary AMAB respondent (91.7 % of non-binary AMAB individuals had insertive oral sex). Every one in three of the sample had engaged in mutual masturbation (88.9 % of trans men, 100 % of trans women, 86.7 % of non-binary AFAB individuals, and 90 % of non-binary AMAB individuals). For transwomen, insertive oral sex was much less common (100 %). Rimming (and getting rimmed) were more common in trans women (33.3 % had ever rimmed and 66.7 % had ever got rimmed) and non-binary AMAB respondents (76.7 % had ever rimmed and 90 % had ever got rimmed), rather than trans men (44.4 % had ever rimmed and 66.7 % had ever got rimmed) and AFAB non-binary respondents (26.7 % had ever rimmed and 53.3 % had ever got rimmed). Trans men (0 %) and non-binary AFAB respondents (25 %) had engaged in receptive vaginal fisting. Receptive anal fisting was less common for these two subgroups (11.1 % of trans men and 6.7 % of non-binary AFAB respondents had engaged in receptive anal fisting) in comparison to trans women (25 %) and non-binary AMAB respondents (13.3 %).

8.3.5 Substance use

The collection of valid data on both licit and illicit drug use is difficult and may be particularly problematic in self-completed, retrospective, large multi-language/national surveys. These problems may result in users under-reporting or misreporting drug use. The problems vary depending on the data being sought and the questions being asked.

8.3.5.1 Use of legal substances

All study participants were asked: *"When was the last time you consumed…"* followed by five different drugs which are not illegal to possess in most of Europe:

- Alcohol (n = 113, missing n = 0);
- Tobacco products (n = 113, missing n = 0);
- Poppers (nitrite inhalants) (n = 113, missing n = 0;
- Viagra, Cialis, Levitra or other substances that help to get/keep an erection (n = 113, missing n = 0);
- Sedatives or tranquillizers (Valium, Rivotril, Rohypnol, Xanax, Seduxen, Phenazepam) (n = 113, missing n = 0).

Table 8.12 shows the cumulative percentages for those who had used each drug within extending time periods. The bottom two rows also show the percentage of respondents having ever taken it in the last 12 months (an indicator of the proportion of users who had quit the drug), and the percentage of respondents who had taken it in the last 12 months who had taken it in the last seven days (an indicator of the frequency of drug use in the population of users).

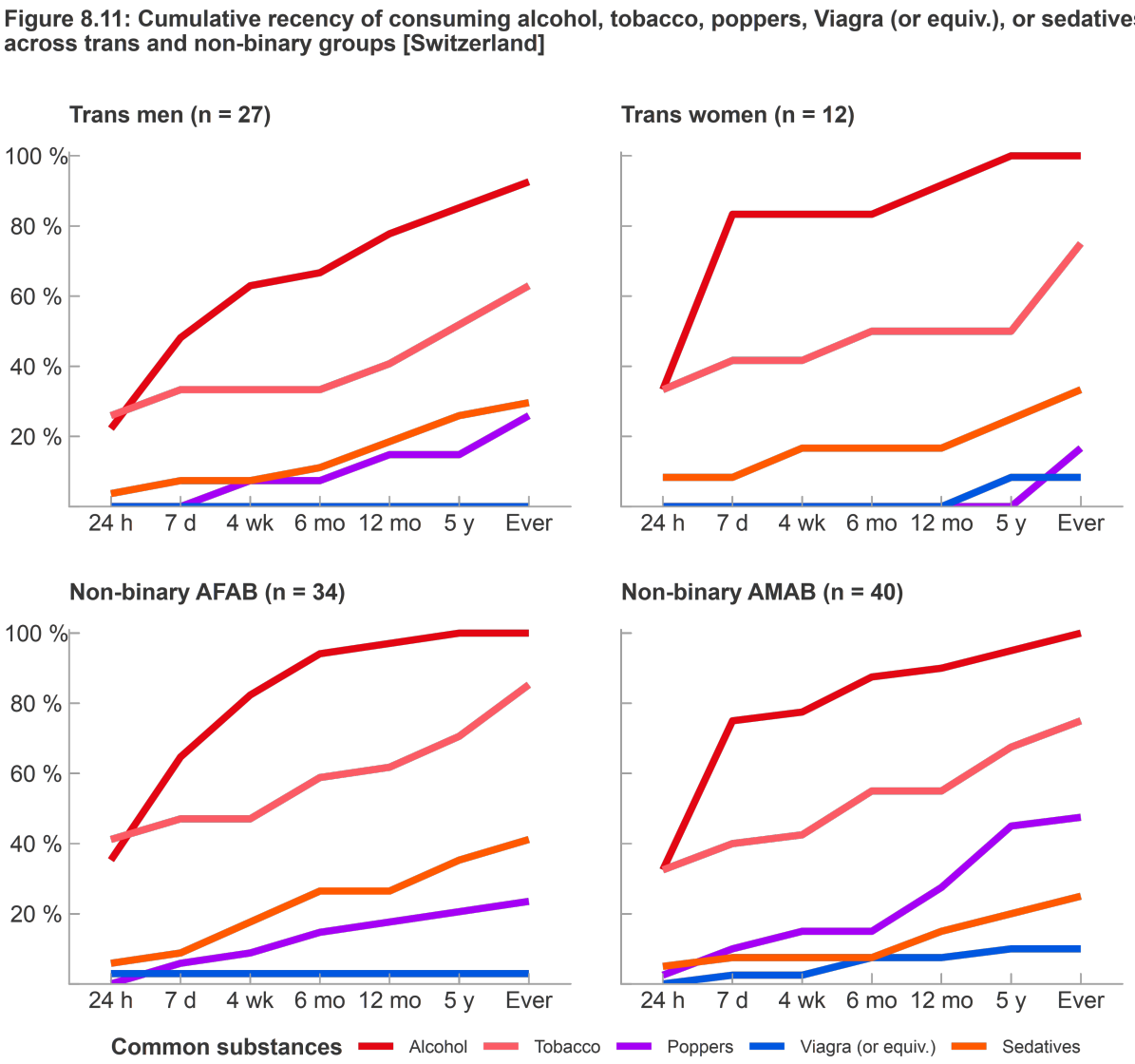
Table 8.12: Use of legal substances

Cumulative %	Alcohol[a] N = 113	Tobacco products[b] N = 113	Poppers[c] N = 113	Viagra etc.[d] N =113	Sedatives etc.[e] N = 113
Within the last 24 hours	37.7	26.1	6.2	4.1	2.5
Within the last 7 days	75.7	31.5	17.9	14.5	3.9
Within the last 4 weeks	86.1	35.3	27.2	22.7	5.5
Within the last 6 months	91.0	40.6	36.1	29.1	8.0
Within the last 12 months	92.6	43.3	43.1	32.7	9.7
Within the last 5 years	94.1	49.7	50.9	36.9	15.2
Ever	96.6	68.9	62.7	40.3	20.6
7 days as a fraction of 12 months	81.7	72.7	41.5	44.3	40.2
12 months as a fraction of ever	95.8	62.9	68.7	81.1	47.1

[a] Missing n = 0; [b] Missing n = 0; [c] Missing n = 0; [d] Missing n = 0; [e] Missing n = 0

Figure 8.11 presents the lifetime prevalence of drug use among different transgender groups, with cumulative percentages calculated for each substance.

Figure 8.11: Cumulative recency of consuming alcohol, tobacco, poppers, Viagra (or equivalent), or sedatives across transgender groups



Alcohol was the most commonly used drug at all time intervals. Lifetime experience of alcohol was 98.2 %, every one in three (31 %) had consumed it in the last 24 hours and every one in two of the sample (66.4 %) in the last seven days. In contrast to alcohol, 33.6 % had used tobacco in the last 24 hours, but the increase in use by 7 days was smaller (7.1 %).

8.3.5.2 Use of recreational or illicit drugs

After being asked about drugs that are not illegal to possess, all study participants were then asked: *"Have you ever taken any other recreational or illicit drugs?"* Overall, 62.8 % answered *"Yes"*.

Those who answered *"Yes"* were then asked: *"When was the last time you consumed…"* followed by the 14 types of illicit drugs below:

- Cannabis (hashish, marijuana)
- Synthetic cannabinoids (*e.g.* "spice", "K2", "herbal incense")
- Ecstasy (E, XTC, MDMA) (as a pill, crystal, or powder)
- Amphetamines (speed)
- Crystal methamphetamine (crystal, meth, "Tina", Pervitin)
- Heroin or related drugs ("poppy straw", "kompot", fentanyl)
- Mephedrone (4-MMC, "meow", methylone, "bubbles")
- Synthetic stimulants other than mephedrone (*e.g.* MXE, bathsalts, 3-MMC, 4-MEC, 4_FA, XTC-light)
- Alpha PhP
- GHB/GBL ("liquid ecstasy")
- Ketamine ("special K")
- LSD ("acid")
- Cocaine
- Crack cocaine

For each drug respondents were offered a scale to indicate how recently they had used it. It should be noted that the questions referred to each drug separately and poly drug use (combining drugs) was not measured [13]. **Table 8.13** and **Table 8.14** shows the cumulative percentage of respondents who had used each drug within each time frame. The bottom two rows also show the percentage of those ever having a drug who had taken it in the last 12 months (an indicator of the historic nature of drug use), and the percentage having taken a drug in the last 12 months who had taken it in the last seven days (an indicator of the frequency of drug use among users).

Table 8.13: Use of recreational or illicit drugs, part 1

Cumulative %	Cannabis[a]	Ecstasy[b]	Amphet-amines[c]	Synthetic stimulants[d]	Alpha PhP[e]	GHB/GBL[f]	Cocaine[g]
Within the last 24 hours	5.3	0.2	0.1	0.3	0.0	0.5	0.7
Within the last 7 days	9.1	1.5	0.4	1.6	0.1	1.8	2.2
Within the last 4 weeks	12.8	3.4	0.5	2.5	0.2	3.0	4.2
Within the last 6 months	19.2	8.6	1.6	4.4	0.2	4.9	8.8
Within the last 12 months	24.1	11.9	2.5	5.7	0.2	7.0	12.5
Within the last 5 years	31.4	17.2	4.3	7.4	0.5	10.5	17.8
Ever	43.4	23.3	7.4	7.6	0.5	14.0	24.0
7 days as a fraction of 12 months	37.8	12.6	16.0	28.1	50.0	25.7	17.6
12 months as a fraction of ever	55.5	51.0	34.0	74.7	37.7	49.8	52.1

[a] Missing n = 0; [b] Missing n = 0; [c] Missing n = 0; [d] Missing n = 1; [e] Missing n = 0; [f] Missing n = 0; [g] Missing n = 0

Figure 8.12: Cumulative recency of consuming illicit substances across transgender groups

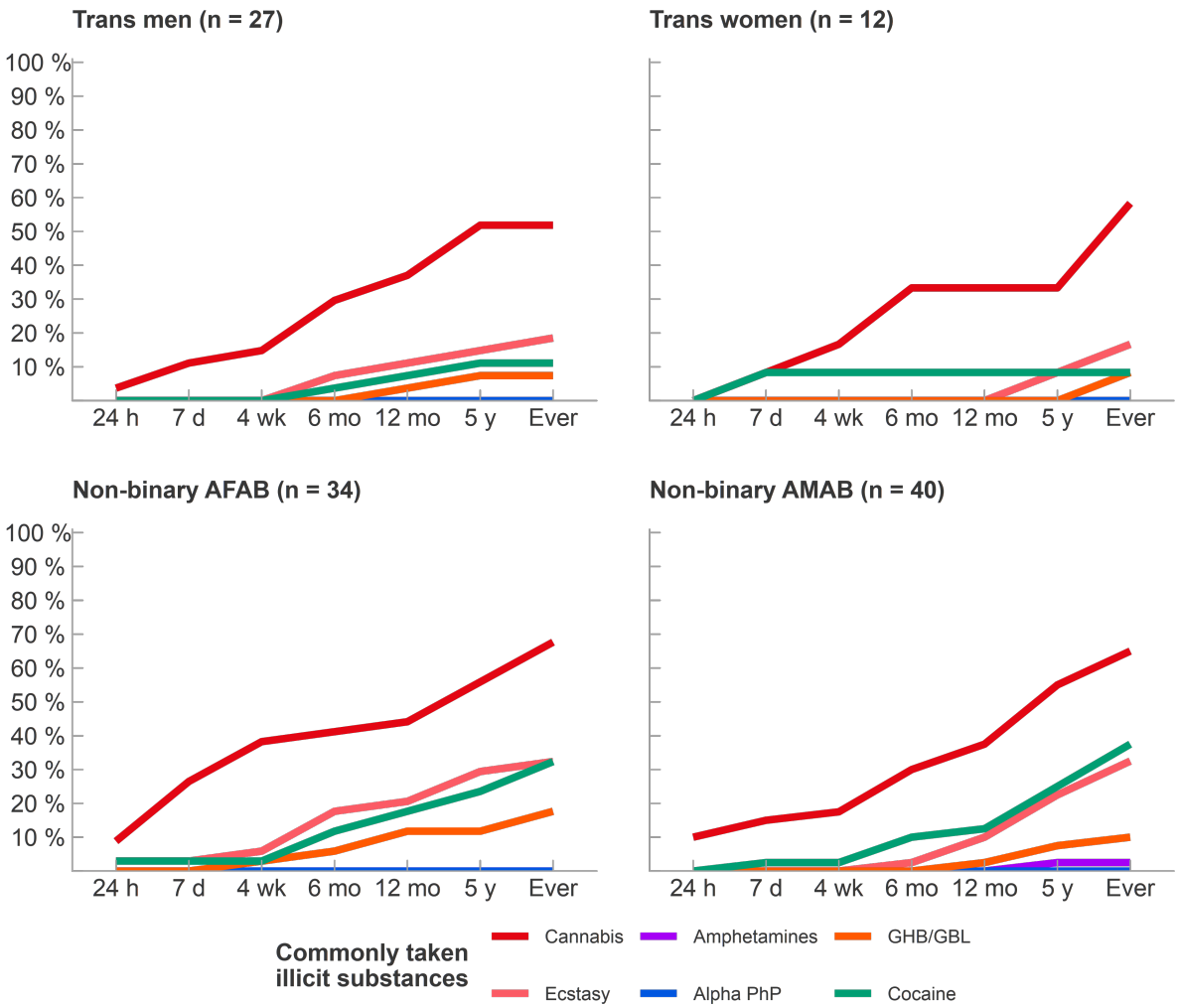


Table 8.14: Use of recreational or illicit drugs, part 2

Cumulative %	Synthetic cannabinoids[a] N = 8	Crystal meth[b] N = 9	Heroin[c] N = 5	Mephedrone[d] N = 4	Ketamine[e] N = 12	LSD[f] N = 24	Crack[g] N = 1
Within the last 24 hours	0.2	0.3	0.1	0.3	0.5	0.1	0.1
Within the last 7 days	0.3	1.4	0.1	1.1	1.3	0.5	0.3
Within the last 4 weeks	0.4	2.5	0.2	2.1	2.1	1.1	0.3
Within the last 6 months	1.2	4.2	0.3	3.9	4.1	3.2	0.6
Within the last 12 months	1.7	5.7	0.3	4.8	6.0	5.4	0.8
Within the last 5 years	2.5	8.0	0.7	6.3	9.0	8.4	1.3
Ever	3.9	9.6	2.0	6.9	11.5	13.3	2.0
7 days as a fraction of 12 months	17.6	24.6	33.3	22.9	21.7	9.3	37.5
12 months as a fraction of ever	43.5	59.2	15.1	69.4	52.0	40.7	40.2

[a] Missing n = 0; [b] Missing n = 0; [c] Missing n = 1; [d] Missing n = 1; [e] Missing n = 0; [f] Missing n = 0; [g] Missing n = 0

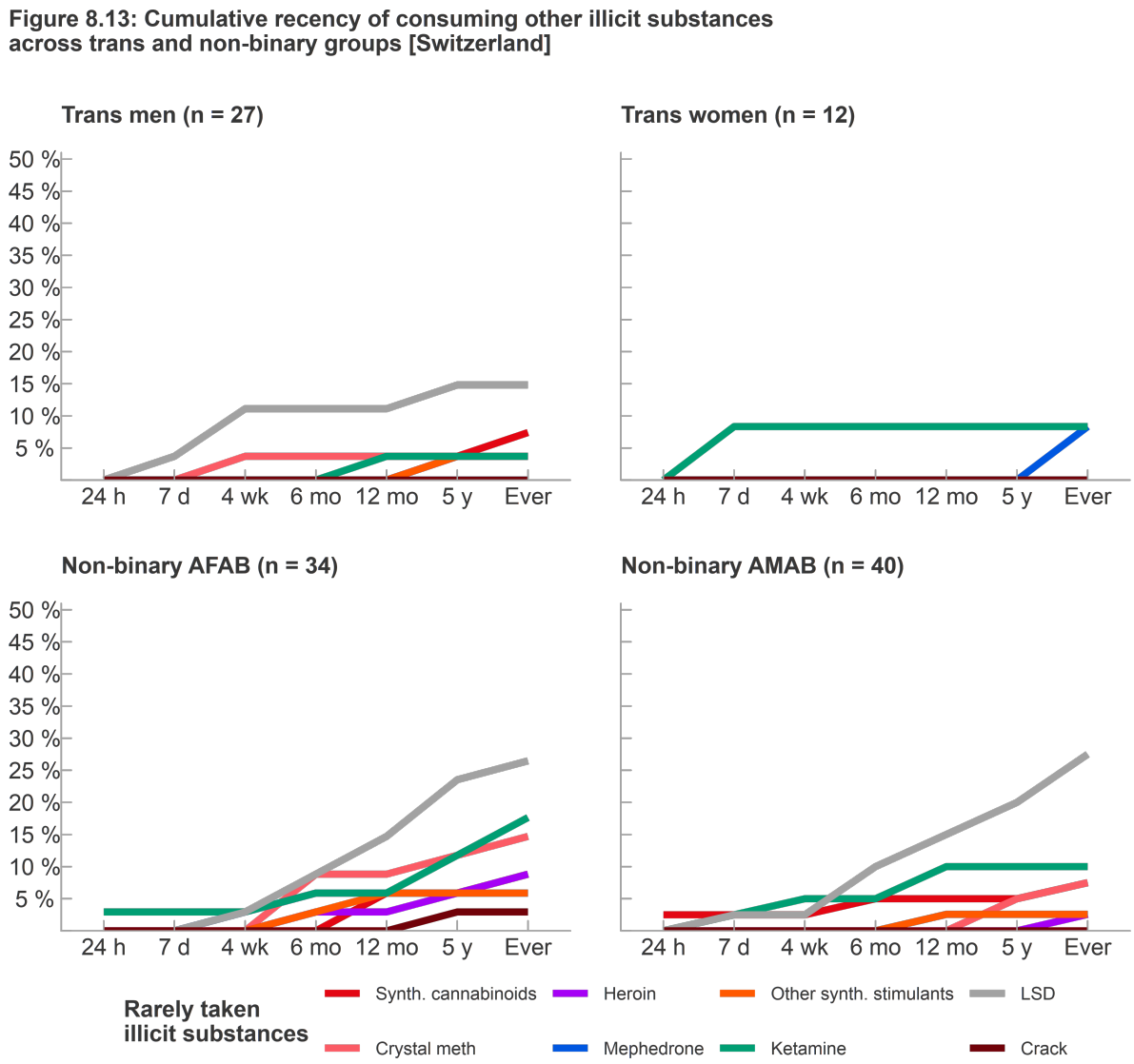
Overall, the five most commonly *ever* used illicit drugs were:

9. Cannabis (43.4 %).
10. Cocaine (24 %).
11. Ecstasy pill (23.3 %).
12. GHB/GBL (14 %).
13. LSD (13.3 %).

While the least *ever* used illicit drugs were: Alpha PhP, Heroin, Crack, Synthetic cannabinoids and Mephedrone.

In the last 12 months, the most commonly used substance was Cannabis (12.8 %). Among the four trans groups, a total of 67.6 % of non-binary AFAB used Cannabis; 65 % among non-binary AMAB; 58.3 % among trans women; and 51.9 % among Trans men. The second most commonly used substance was Cocaine. A total of 37.5 % for non-binary AMAB; 32.4 % for non-binary AFAB; 18.5 % for trans men; and 16.7 % for trans women. The third most commonly used substance was *Ecstasy*. A total of 32.5 % for non-binary AMAB; 32.4 % for non-binary AFAB; 11.1 % for trans men; and 8.3 % for trans women.

Figure 8.13: Cumulative recency of consuming other illicit substances across transgender groups



Among the four trans groups, the most common *ever* used substance was *LSD*. A total of 27.5 % among non-binary AMAB; 26.5 % among non-binary AFAB; 14.8 % among trans men; and 8.3 % among trans women. Followed by *Ketamine*. A total of 17.6 % among non-binary AFAB; 10 % among non-binary AMAB; 8.3 % among trans women; and 7.4 % among trans men. Followed by *Crystal meth*. A total of 14.7 % among non-binary AFAB; 7.5 % among non-binary AMAB; 3.7 % among trans men; and 0 % among trans women.

8.3.6 Combining sex and drugs

Chemsex has become a public health issue since EMIS-2010. Chemsex is a category of behaviour for which there is no agreed definition [14]. While all definitions include the combining of sex and substances, not all sex under intoxication is considered chemsex. Other necessary features of a chemsex definition may include sex between men or transgender people; sex between casual partners and/or fuck-buddies (*i.e.* not between those romantically involved); facilitation by smartphone dating apps; use of specific drugs (typically GHB/GBL, crystal methamphetamine, mephedrone, and/or ketamine) [15]. Defining chemsex and developing an acceptable measure that was appropriate across cultures was a major challenge [16]. We decided not to use the word 'chemsex' in the survey itself and to ask a series of both broader and narrower questions.

8.3.6.1 Sex under intoxication

All study participants who had sex with men in the last 12 months 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?"* and were offered the responses in **Table 8.15**.

Table 8.15: Percentage of all sex with men that was under the influence of alcohol or any other drug in the last 12 months

Percentage of all sex with men that has been under the influence of alcohol or any other drug in the last 12 months N = 77	% of trans men	% of trans women	% of non-binary AFAB	% of non-binary AMAB	% of all
None of it	55.6	75	47.6	35.3	45.5
Almost none of it	33.3	0	4.8	26.5	20.8
Less than half	0.0	25	19.0	14.7	13.0
About half	0.0	0	0.0	17.6	7.8
More than half	5.6	0	9.5	0.0	3.9
Almost all of it	5.6	0	9.5	0.0	3.9
All of it	0.0	0	9.5	5.9	5.2
Total	**100**	**100**	**100**	**100**	**100**

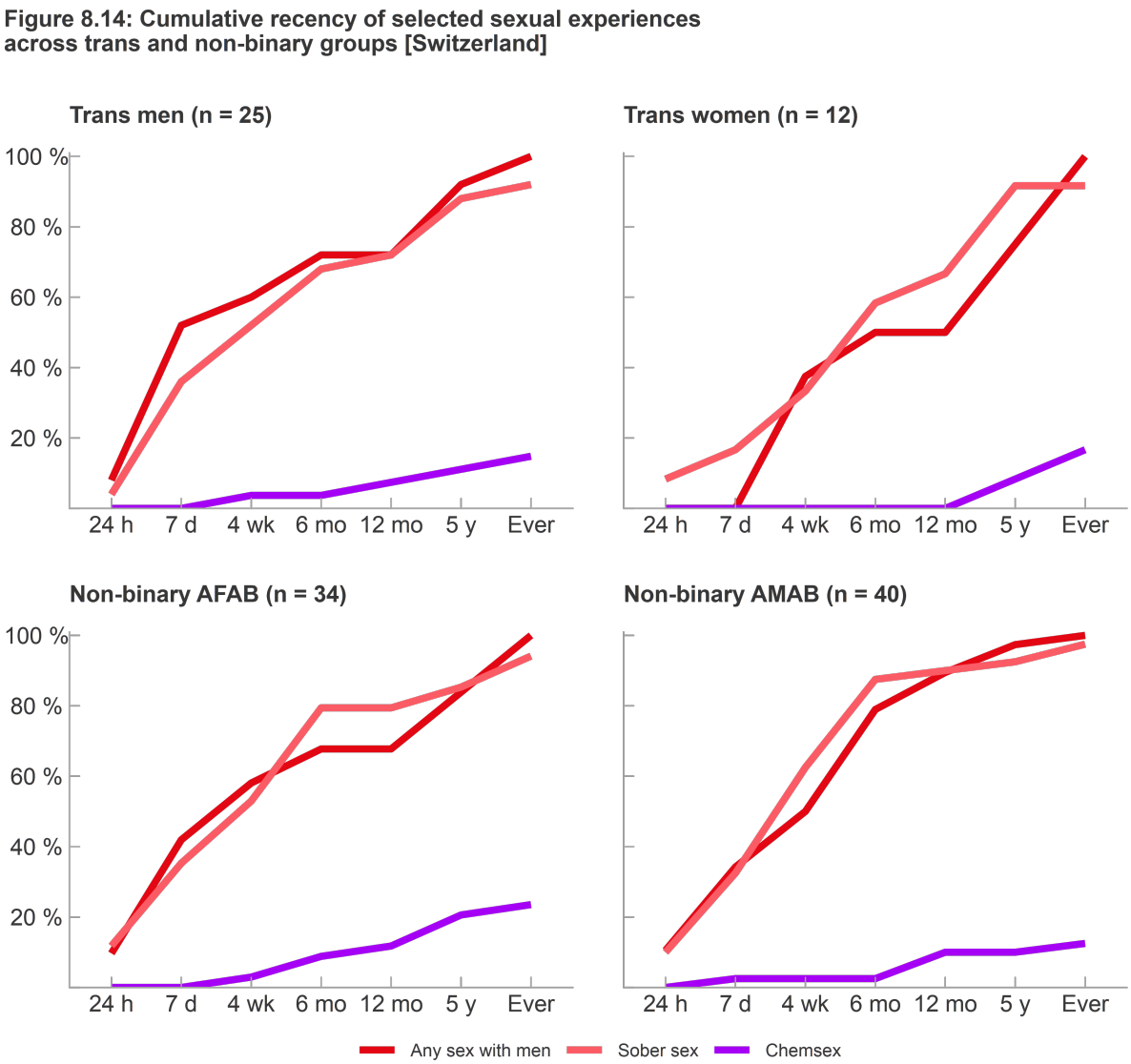
* Missing n = 0

Overall, 20.8 % indicated that at least half of the sex they had had was under intoxication, with 9.1 % indicating that all or almost all of the sex they had had was under intoxication. Conversely, 45.5 % indicated that none of the sex they had had was under intoxication. It is worth noting that this question includes sex that occurs while using drugs and alcohol and drug use that is specifically intended to facilitate, alter, or enhance sex.

8.3.6.2 Sober sex and 'Chemsex'

All study participants were asked: *"When was the last time you had sober sex (that is, NOT under the influence of alcohol or any other drug)?"* and were offered a scale to indicate how recently this had occurred. Followed by, *"When was the last time you used stimulant drugs to make sex more intense or last longer? (Note: the stimulant drugs include ecstasy/MDMA, cocaine, amphetamine (speed), crystal methamphetamine (Tina, Pervitin), mephedrone, ketamine, and Alpha PhP)"* and were offered a scale to indicate how recently this had occurred. The behaviour defined in this last question will, for ease of reference, hereafter be referred to as chemsex. We choose to focus our measurement on intentional use of stimulant drugs for intensification and extension of sex. We recognise this is not a definitive measurement of chemsex (there can be no such thing) but it has the benefit of precision and clarity.

Figure 8.14: Cumulative recency of selected sexual experiences across transgender groups



Sober sex was far more common than chemsex (94.6 % of trans and non-binary respondents had engaged in sober sex). Overall, 16.8 % of trans and non-binary respondents had ever engaged in chemsex, 9.5 % of whom had done so in the last 12 months. Non-binary AMAB individuals were the group who engaged the most in chemsex (12.5 % of non-binary AMAB respondents has engaged in chemsex), followed by trans women (16.7 %), compared to a smaller percentage of non-binary AFAB individuals (23.5) % and trans men (14.8 %).

8.3.6.3 Features of Chemsex

Study participants who had ever had chemsex were asked: *"When was the last time you combined stimulant drugs and sex with more than one man at the same time?"* and were offered a scale to indicate how recently this had occurred. We refer to this behaviour as 'multi-partner chemsex'.

Table 8.16: Location of most recent sex with stimulants and multiple partners sample who had multi-partner chemsex in the last 12 months

Location of most recent sex with stimulants and multiple partners* N = 1	% of transgender respondents who had multi-partner chemsex in the last 12 months
In a club or backroom of a bar	100

* Missing n = 0

8.4 Needs

We define sexual health needs as the capabilities, opportunities, and motivations to engage in sexual health related behaviour, both precautions and risks. A central research objective of EMIS was to identify sexual health needs that are commonly unmet across the population of transgender and non-binary people in order to prioritise those needs for intervention. EMIS asked about needs related to several type of precautionary behaviour and health outcomes. It also asked about some health needs not related to specific behaviour, including social support and internalised transnegativity.

8.4.1 Transphobic stigma and discrimination

All study participants were asked: *"Please say when something last happened, even if this was not typical for you"* and were presented with items relating to social, healthcare-related, or law enforcement-related discrimination.

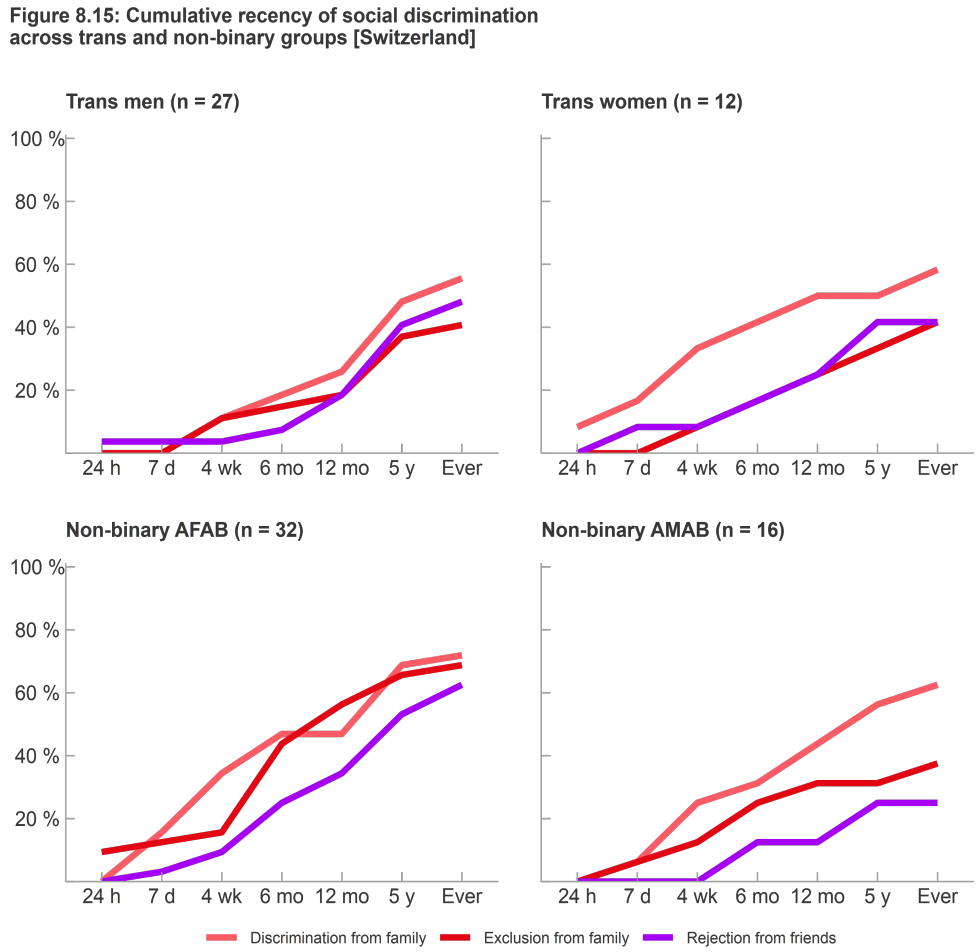
8.4.4.1 Social discrimination

Study participants were asked: *"When was the last time you…"* followed by three statements:

- *"…ever felt excluded from family activities because you are transgender?"*
- *"…ever felt that family members have made discriminatory remarks or gossiped about you because you are transgender?"*
- *"…ever felt rejected by your friends because you are transgender?"*

Overall, 63.2 % felt they were discriminated by their family because they are transgender, and 50.6 % felt excluded by their family. Around one in two trans and non-binary respondents (48.3 %) felt rejected by their friends because they are transgender.

Figure 8.15: Cumulative recency of social discrimination across transgender groups



8.4.4.2 Healthcare-related discrimination

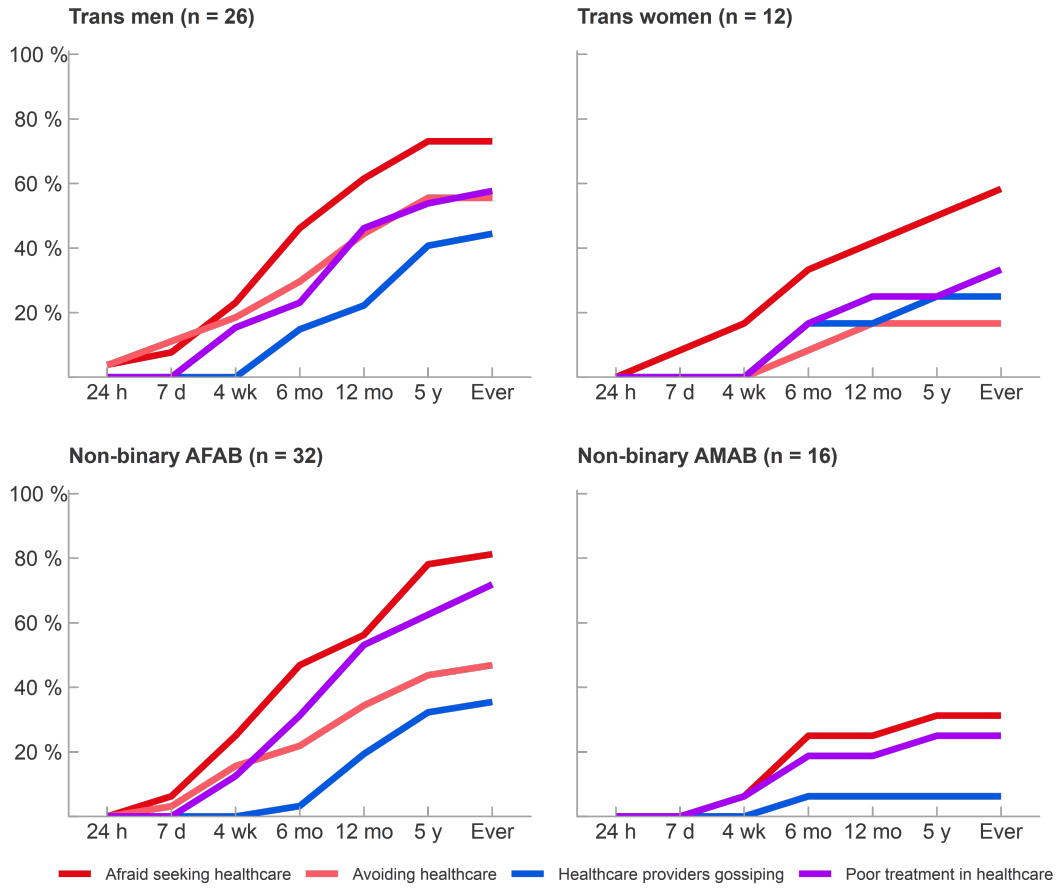
Study participants were asked: *"When was the last time you…"* for the following items about healthcare-related discrimination:

- *"…ever felt afraid to go to health care services because you worry someone may learn you are transgender?*
- *"…ever avoided going to health care services because you worry someone may learn you are transgender?*
- *"…ever felt that you were not treated well jn a health centre because someone knew you are transgender?*
- *"…ever heard health care providers gossiping about you (talking about you) because you are transgender?*

Around two out of three trans and non-binary respondents (66.3 %) felt afraid seeking healthcare because they worried someone may learn they are transgender, and 37.9 % of trans and non-binary respondents avoided going to health care facilities for the same worry. These feelings were especially prominent in trans men (73.1 % of whom reported feeling afraid seeking healthcare, and 55.6 % of whom avoided seeking healthcare services) and non-binary AFAB individuals (of whom 62.5 % reported feeling afraid of seeking health care services, and (55.6 % of whom avoided seeking them). Around one out of two (53.5 %) of trans and non-binary respondents felt they were receiving poor treatment in a health care setting, and 31.4 % of trans and non-binary respondents heard their health care providers gossip about them because they are transgender.

Figure 8.16: Cumulative recency of transphobic healthcare-related discrimination across transgender groups

Figure 8.16: Healthcare related stigma and discrimination across trans and non-binary groups [Switzerland]



4.4.1.3 Law enforcement-related discrimination

Study participants were asked: *"When was the last time you…"* for the following items related to social discrimination:

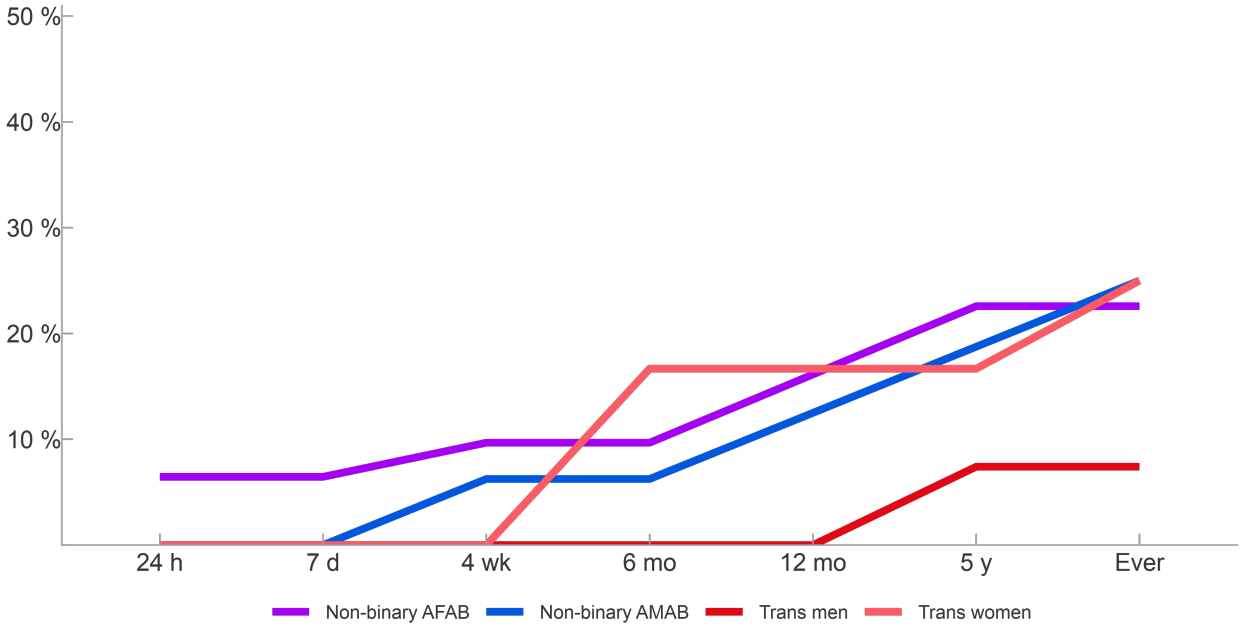
- *"…ever felt that the police refused to protect you because you are transgender?"*

18.6 % of trans and non-binary respondents felt that the police refused to protect them because they are transgender. This feeling was more commonly reported by transgender women (25 % of whom felt the police refused to protect them because they are transgender) and non-binary AMAB individuals (25 % of whom felt the police refused to protect them because they are transgender).

Figure 8.17: Cumulative recency of transphobic law enforcement-related discrimination across transgender groups

Figure 8.17: Cumulative recency of transphobic law enforcement-related discrimination across trans and non-binary groups [Switzerland]

Trans men (n = 27); Trans women (n = 12); Non-binary AFAB (n = 31); Non-binary AMAB (n = 16)



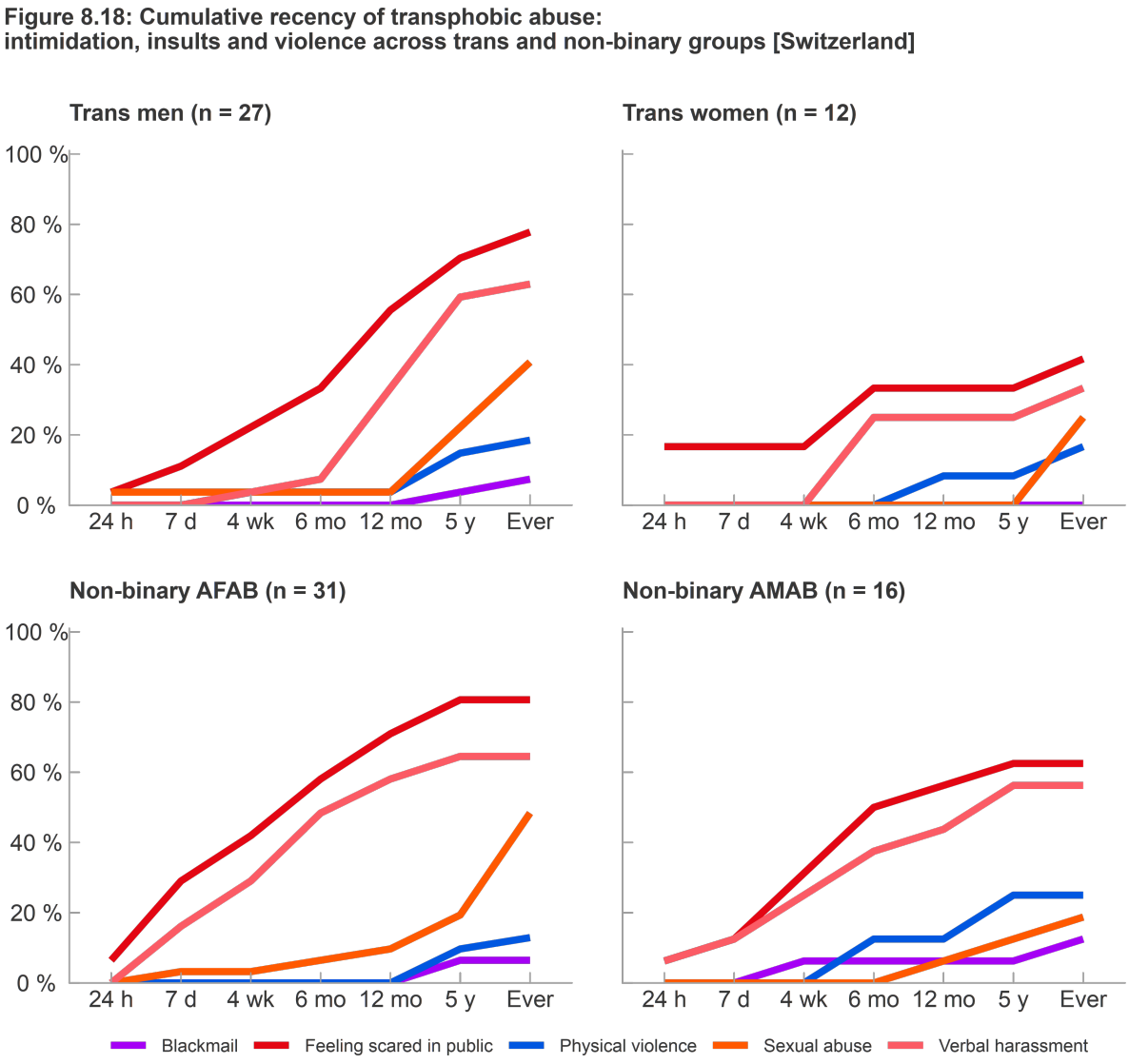
8.4.2 Transphobic abuse

All study participants were asked: *"Please sat when something last happened, even if this was not typical for you"* followed by three statements:

- *"…ever felt scared to be in public places because someone knew or presumed you are transgender?*
- *"…ever been verbally harassed because someone knew or presumed you are transgender?*
- *"…ever been blackmailed by someone because someone knew or presumed you are transgender?*
- *"…ever someone physically hurt you (pushed, shoved, slapped, hit, kicked, choked or otherwise physically hurt you) because someone knew or presumed you are transgender?*
- *"…ever someone forced you to have sex when you did not want to? (By forced, we mean physically forced, coerced to have sex, or penetrated with an object, when you did not want to)*

For each statement, study participants were offered a scale to indicate how recently this had occurred. The cumulative percentages for having experienced each event are shown in **Figure 8.18**.

Figure 8.18: Cumulative recency of transphobic abuse: intimidation, insults and violence across transgender groups



Around 61 of trans and non-binary respondents (70.9 %) had ever felt scared to be in public spaces because someone knew or presumed, they were transgender, and 58.1 % indicated ever being verbally harassed because someone knew or presumed, they were transgender. 7 % of trans and non-binary respondents had ever been physically hurt because someone knew or presumed, they were transgender, and 37.2 % of trans and non-binary respondents had ever been coerced into having sex.

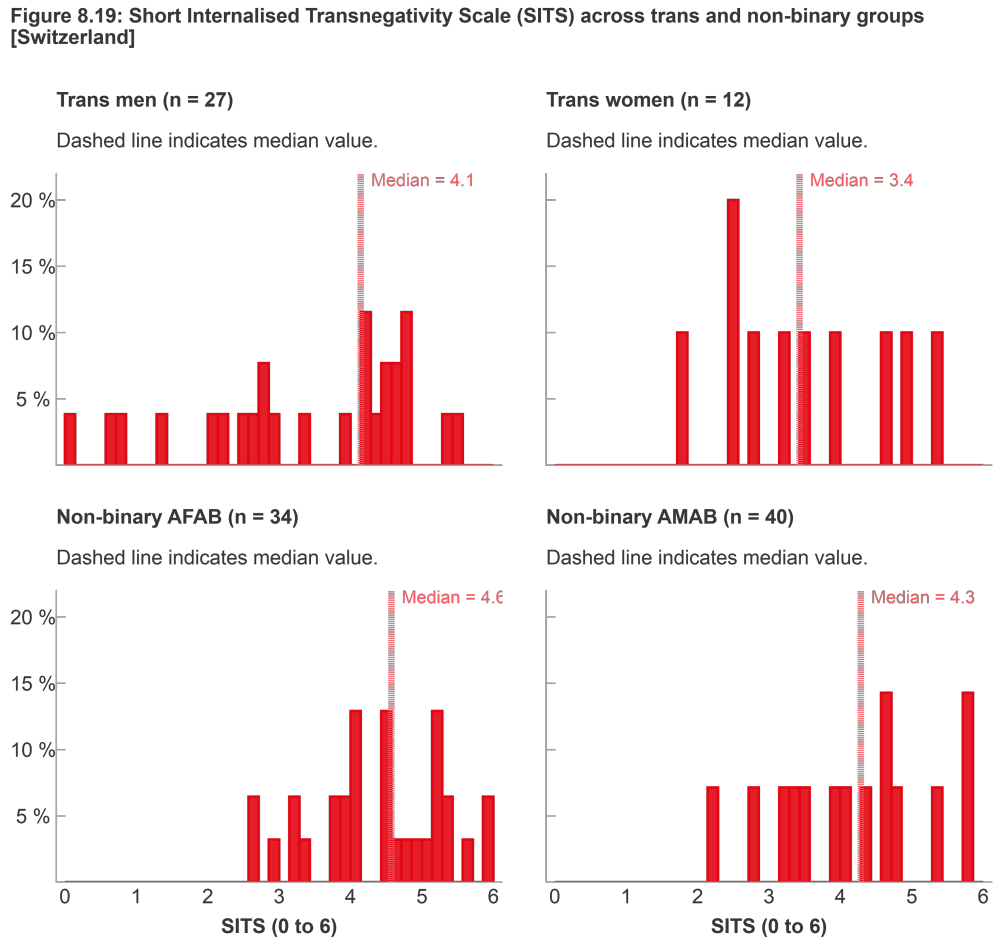
8.4.3 Internalised Transnegativity

We used a Short Internalised Transnegativity Scale (SITS), adapted from Tran *et al.* [17] to estimate the extent of internalised transnegativity in the sample. Study participants were asked: *"Do you disagree or agree with the following statements on a scale of 1 (Strongly disagree) to 7 (Strongly agree)? Please do not spend too much time thinking about any one statement"*. They were presented with the following seven items:

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

For scoring, items reflecting positive feelings towards their transgender identity were reverse-coded (*e.g.*, a response of '1' was scored as 6, and '7' as 0) while items reflecting negative feelings were scored directly (*e.g.*, '1' was scored as 0, and '7' as 6). This transformation resulted in individual item scores ranging from 0 to 6. A total SITS score (0 to 42) was calculated by summing the responses across all seven items, and this total was then divided by 7 to yield a mean SITS score, which ranges from 0 to 6. The **Figure 8.19**, below, shows how these mean SITS scores are distributed across the transgender and non-binary sample of our survey and across each identity. Ideally, we would want all scores to be as low as possible (*i.e.*, to be on the extreme left), as this indicates less internalised transnegativity. The seven responses add up to a score between 0 and 42, which is then divided by 7 to give a score between 0 and 6. Please note that this scale is an adaptation of the original from Tran *et al.* [17] and has not been validated for this specific application. Exercise caution when interpreting the results.

Figure 8.19: Short Internalised Transnegativity Scale (SITS)



8.4.4 Stress within the community

This section, adapted for the transgender community, is based on the **intra-minority stress theory** (also known as the gay community stress theory), developed by Pachankis *et al.* [18]. The theory integrates three foundational frameworks—intra-sex competition theory [19], sexual field theory [20], and theory of precarious manhood [21] —to explain mental health disparities. The theory describes how stress from status hierarchies within the transgender community can intensify stress related to social hierarchies, and thereby contributing to mental health challenges. We used a modified, 9-item scale relevant to the transgender community to measure this stress. The scale focuses on racial or ethnic marginalisation, competition and comparison, and rejection from the mainstream LGBTQ+ community. Responses were rated on a 5-point Likert scale (1 = "Strongly Disagree", to 5 = "Strongly Agree"), where higher scores indicate greater perceived intra-minority stress.

8.4.4.1 Stressors related to competition

Study participants were asked to rate on a 5-point "Disagree-Agree" scale the following questions:

- *The mainstream transgender community is overly gossipy*
- *The mainstream transgender community has a culture of competition and jealousy*
- *The mainstream transgender community is overly cliquey*
- *In the mainstream transgender community, there is a lot of mistrust among friends*
- *The mainstream transgender community is overly judgemental*
- *The mainstream transgender community is overly materialistic*

Table 8.17 shows the percentages of their response to each statement.

A total of 17 % reported high competition-related stress, with a mean score of 3.2.

Table 8.17: Perceived competition within the mainstream trans community

Competition subscale agreement statements	Strongly disagree	Disagree	Neither / not sure	Agree	Strongly agree
The mainstream transgender community is overly gossipy[a] n = 85[b]	14.1	35.3	36.5	11.8	2.4
The mainstream transgender community has a culture of competition and jealousy[c] n = 85[d]	22.4	25.9	29.4	20.0	2.4
The mainstream transgender community is overly cliquey[e] n = 85[f]	17.6	24.7	29.4	22.4	5.9
In the mainstream transgender community, there is a lot of mistrust among friends n = 84	41.7	27.4	23.8	6.0	1.2
The mainstream transgender community is overly judgmental n = 84	15.5	32.1	27.4	19.0	6.0
The mainstream transgender community is overly materialistic n = 85	29.4	24.7	34.1	10.6	1.2

[a] Missing n = 2; [b] Missing n = 2; [c] Missing n = 2; [d] Missing n = 3; [e] Missing n = 3; [f] Missing n = 2

Overall, around one in two (49.4 %) disagreed that that the mainstream transgender community is overly gossipy, and 36.5 % were not sure. Similarly, most trans and non-binary respondents (48.2 %) disagreed that the mainstream transgender community has a culture of competition and jealousy, while 22.4 % agreed. 42.4 % of our sample disagreed that the mainstream transgender community is overly cliquey, and around two out of three trans and non-binary respondents (69 %) disagreed that there is lots of mistrust among friends within the community. Respondents also tended to disagree that the mainstream transgender community is overly judgemental (47.6 % of trans and non-binary respondents disagreed) and materialistic (54.1 % disagreed).

8.4.4.2 Stressors related to exclusion

Study participants were asked to rate on a 5-point "Disagree-Agree" scale the following questions:

- *The mainstream transgender community is racist*
- *The mainstream transgender community discriminates against its members who have HIV/AIDS*
- *In the mainstream LGBTQ+ community, there is lots of transphobia*

Table 8.18 shows the percentages of each statement based on their response.

Table 8.18: Perceived exclusion within the trans community

Exclusion subscale agreement statements	Strongly disagree	Disagree	Neither / not sure	Agree	Strongly agree
The mainstream transgender community is racist n = 87	23.0	18.4	39.1	16.1	3.4
The mainstream transgender community discriminates against its members who have HIV/AIDS n = 87	26.4	21.8	41.4	8.0	2.3
In the mainstream LGBTQ+ community, there is lots of transphobia n = 87	5.7	13.8	24.1	43.7	12.6

* Missing n = 0; ** Missing n = 0; *** Missing n = 0

Overall, around one in three trans and non-binary respondents (41.4 %) disagreed with the notion that the trans community is racist, 39.1 % were not sure, and 19.5 % agreed. Around one in three trans and non-binary respondents disagreed (48.3 %) that the trans community discriminates against its members who have HIV/AIDS, and a slightly lower percentage of 41.4 % was not sure. 10.3 % instead agreed with the statement. Overall, there was a tendency to agree (56.3 %) that there is lots of transphobia among the LGBTQ+ community. A small percentage of trans and non-binary respondents disagreed (19.5 %), and 24.1 % responded *"Neither"*.

A total of 14.6 % reported high exclusion-related stress, with a mean score of 3.4.

8.4.5 PrEP Knowledge

Study participants were asked, "*Have you heard of PrEP?"* Overall, 87.5 % indicated *"Yes"*, and 12.5 % had not heard of it.

Trans and non-binary study participants were also told: *"The following statements are all TRUE. Did you know this already?"* and were offered the following statements:

- *Pre-Exposure prophylaxis (PrEP) involves someone who does not have HIV taking pills before as well as after sex to prevent them getting HIV*
- *PrEP can be taken as a single daily pill if someone does not know in advance when they will have sex*
- *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*
- *Gender-affirming hormone therapy with testosterone does not affect PrEP efficacy in any way*
- *If you are on oestrogen as part of your gender-affirming hormones, PrEP is effective only if taken in the modality of a single daily pill*

Table 8.19 shows the percentages indicating each response.

The column on the right adds together respondents who did not already know the statement was true (*i.e.* everyone who did not select *"Already knew"*).

The fourth statement (*"Gender-affirming hormone therapy with testosterone does not affect PrEP efficacy in any way"*) was offered only to transgender men and AFAB non-binary individuals who selected that they were on or planned to take gender-affirming hormones. Similarly, the last statement (*"If you are on oestrogen as part of your gender-affirming hormones, PrEP is effective only if taken in the modality of a single daily pill"*) was offered only to transgender women and AMAB non-binary individuals who indicated taking or planning to take gender-affirming hormones. Following these items, study participants were told: *"Please note: taking PrEP just before and after sex has been shown to be protective in anal but not vaginal intercourse"*.

Table 8.19: HIV testing and treatment knowledge

% of all trans respondents	Already knew	Wasn't sure	Didn't know	Don't understand	Do not believe
Pre-Exposure prophylaxis (PrEP) involves someone who does not have HIV taking pills before as well as after sex to prevent them getting HIV[a] n = 112[b]	63.4	18.8	17.0	0.9	36.6
PrEP can be taken as a single daily pill if someone does not know in advance when they will have sex[c] n = 112[d]	57.1	16.1	25.9	0.9	42.9
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[e] n = 112	31.2	22.3	45.5	0.9	68.8
Gender-affirming hormones therapy with testosterone does not affect PrEP efficacy in any way n = 48	29.2	31.2	39.6		70.8
If you are on oestrogen as part of your gender-affirming hormones, PrEP is effective only if taken in the modality of a single daily pill n = 14			100.0		

[a] Missing n = 0; [b] Missing n = 0; [c] Missing n = 0; [d] Missing n = 0; [e] Missing n = 0

Around one in six of trans and non-binary respondents (63.4 %) were aware that PrEP involves someone who does not have HIV taking pills before and after sex to prevent HIV, 17 % didn't know and 18.8 % was not sure. 57.1 % of trans and non-binary respondents already knew that PrEP can be taken as a single daily pill, 25.9 % did not know and 16.1 % was not sure. Around one in three trans and non-binary respondents (29.2 %) knew that PrEP can be taken as a double dose 2–24 hours before sex and then both at 24 and 48 hours after the double dose, while a clear majority of trans and non-binary respondents (70.8 %) did not already know. All trans and non-binary respondents (100 %) *did not know* that if they are on oestrogen as part of your gender-affirming hormones, PrEP is effective only in taken in the modality of a single daily pill.

8.4.6 Sexual rejection

Overall, most trans and non-binary respondents (78.3 %) indicated that they rarely or never got rejected by a man because they are transgender, while 21.7 % got rejected at least half of the time.

Table 8.20: Sexual rejection experiences from men based on transgender identity

Sexual rejection[*] N = 83	% of trans men	% of trans women	% of non-binary AFAB	% of non-binary AMAB	% of all
Most of the time	12.5	9.1	6.2	6.2	8.4
Rarely	41.7	18.2	31.2	50.0	36.1
Never	25.0	54.5	50.0	43.8	42.2
Total	**100**	**100**	**100**	**100**	**100**

[*] Missing n = 1

8.5 Interventions

To intervene is to participate in an activity so to alter a course of events, usually to make something less or more likely to occur.

Interventions can be positive (meeting needs) or negative (undermining needs and generating unmet need). Positive interventions include education, health and social services, as well as the myriad ways in which community members help each other. Negative interventions include transphobic legislation, exclusion and abuse.

8.5.1 Gender-affirming hormone therapy

Some transgender people may entrust themselves to gender-affirming hormone therapy, to alleviate the distress caused by the experience of gender dysphoria—referring to the discomfort or distress that a person experiences due to incongruence between gender identity and sex assigned at birth. For instance, trans men and AFAB non-binary people can take testosterone, while trans women and AMAB non-binary people can take oestrogen and optionally androgen blockers [22]. Non-binary people, on the other hand, are less likely to seek gender-affirming hormone therapy. This may be because they experience less body dissatisfaction or gender incongruence, or, significantly, because of the obstacles and challenges they face in accessing care. Barriers and difficulties in accessing gender-affirming hormone therapy may pose significant burdens on the mental and sexual health of trans and non-binary people.

All transgender and non-binary study participants were asked: *"Are you currently taking gender-affirming hormones?"* and offered the responses *"Yes"*, *"No"*, *"I was, but not anymore"*. If they answered *"No"*, they would be asked: *"Do you plan on starting gender-affirming hormones in the future?"* and offered *"Yes"*, *"No"*, *"Not sure"* as responses.

Table 8.21 summarises the responses.

Table 8.21: Use of Gender-Affirming Hormones

Use of gender-affirming hormones* N = 87	% of trans men	% of trans women	% of non-binary AFAB	% of non-binary AMAB	Total
Currently not taking gender affirming hormones	14.8	41.7	34.4	75.0	165.9
..planning to start	11.1	41.7	15.6	0.0	68.4
..undecided on starting	3.7	0.0	9.4	25.0	38.1
Currently taking gender affirming hormones	85.2	58.3	53.1	18.8	215.4
..not planning to start	0.0	0.0	9.4	50.0	59.4
Previously took gender affirming hormones, but not anymore	0.0	0.0	12.5	6.2	18.7

* Missing n = 0

Most binary trans people were either already taking (85.2 % of trans men vs. 58.3 % of trans women) or planning to take (3.7 % of trans men vs. 41.7 % of trans women) gender-affirming hormones.

Around one in seven non-binary AFAB individuals are currently taking (53.1 %) gender-affirming hormones, 9.4 % are not planning to start, and 12.5 % were already taking, but not anymore. 50 % of non-binary AMAB individuals did not plan to start hormones, and only a around one in 33 were already taking it (18.8 %).

Table 8.22: Gender-affirming hormones monitoring

% gender affirming hormones monitoring* N = 50	% of trans men	% of trans women	% of non-binary AFAB	% of non-binary AMAB
Yes, by a medical specialist (e.g. endocrinologist)	91.3	71.4	88.2	100
Yes, by my general practitioner/ family doctor	8.7	0.0	5.9	0
No, I am being helped by someone else (who is not my healthcare provider)	0.0	14.3	0.0	0
No, I am monitoring my gender-affirming therapy myself	0.0	14.3	5.9	0

* Missing n = 0

A clear majority (88 %) indicated that they were currently being monitored by a medical specialist for their gender-affirming therapy, and 6 % of trans and non-binary respondents were monitored by their general practitioner. Around 4 % of trans and non-binary respondents on gender-affirming hormones indicated that they were monitoring their gender-affirming therapy on their own (colloquially called "DIY").

Respondents who indicated *"I was, but not anymore"*, to *"Are you currently taking gender-affirming hormones?"*, received a follow-up question: *"Why are you not on gender-affirming hormones anymore?"* and the responses are shown in **Table 8.23**.

Table 8.23: Reasons for not taking gender-affirming hormones any more

% reason of not taking hormones anymore* N = 5	% of trans men	% of trans women
I decided to stop them	75	0
Other reasons	25	0
I had to stop them for medical reasons	0	100

* Missing n = 0

Respondents who indicated *"Yes"* to *"Are you currently taking gender-affirming hormones?"*, received a follow-up question: *"Where have you got your gender-affirming hormones from? (Tick as many as apply)"*. The responses are shown in **Table 8.24**.

Table 8.24: Source of gender-affirming hormones

Source of gender affirming hormones* N = 50	% of trans men	% of trans women	% of non-binary AFAB	% of non-binary AMAB
General practitioner/family doctor	6	0	2	0
Medical specialist (e.g. endocrinologist)	38	8	26	0
Community health service or drop-in (not in a hospital or clinic)	2	0	2	0
Online pharmacy / abroad	0	0	2	0
Physical pharmacy in the country I live in	0	2	2	4
Friend and/or partner	0	0	0	2
'Drug dealer' or on the 'black market'	0	2	0	0
Gender-affirming care service	0	2	0	0

* Missing n = 63

A clear majority of trans and non-binary respondents (72 %) indicated getting their gender-affirming hormones from a *Medical specialist*, shortly followed by their *General Practitioner* (8 %). 2 % of the trans and non-binary respondents get their hormones from a *Gender-affirming care service*, around one in twelve a *physical pharmacy* in the country they live in (8 %), an *online pharmacy* (2 %), or an hospital, clinic, or institute (0 %).

8.5.2 Source of PrEP

Study participants who had ever used PrEP were asked: *"Where have you got your PrEP pills from?"*. **Table 8.25** shows the percentage of their responses.

Table 8.25: Sources of PrEP pills who had ever taken PrEP

Source of PrEP* N = 18	% of trans and non-binary respondents
As a participant in a research study	38.9
General Practitioner / family doctor	27.8
A doctor in private practice	0.0
At a hospital, clinic or Institute	0.0
At a community health service or drop-in	55.6
From an online pharmacy/abroad	0.0
From a physical pharmacy in the country	5.6
Used PEP pills as PrEP	0.0
Used someone else's ART pills as PrEP	0.0
Given by friend or partner	0.0
At a gender-affirming care service	5.6
Other	5.6

* Missing n = 95

Around one out of two trans and non-binary respondents got PrEP from *"At a community health service or drop-in"* (55.6 %), *"as a participant in a research study"* (38.9 %), and *"general Practitioner / family doctor"* (27.8 %).

8.5.3 Testing services

Sexual health information (and health information generally) is more likely to be attended to if it is tailored to the circumstances and preferences of its target group.

Study participants were asked: *"When was the last time you saw or heard any information about HIV or STIs specifically for transgender people?"* and were offered a scale for indicating how recently this had occurred.

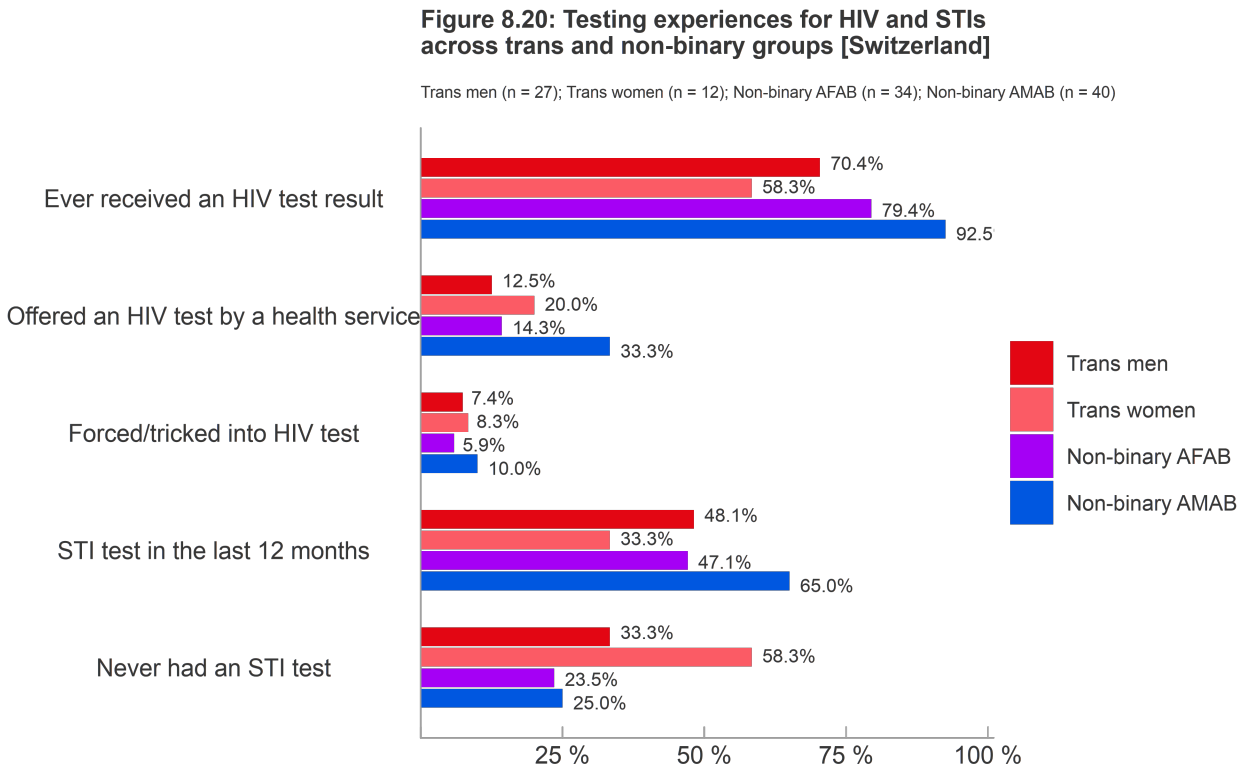
8.5.3.1 HIV/STI education services

Around one in four (27.7 %) indicated to have "*Never*" seen any specific information about HIV or STIs for transgender people while 25.9 % had done so *"within the last six months"*.

8.5.3.2 HIV/STI testing services

Regulations regarding HIV testing have been relaxed in many European countries, and HIV tests can be accessed in a variety of settings, including community-based testing (often in the absence of physicians via trained personnel), self-sampling and self-testing [23]. This section considers how far HIV testing is penetrating, which services are providing the tests, whether men are satisfied with them and whether health services are pro-active in offering HIV tests.

Figure 8.20: Testing experiences for HIV and STIs across transgender groups



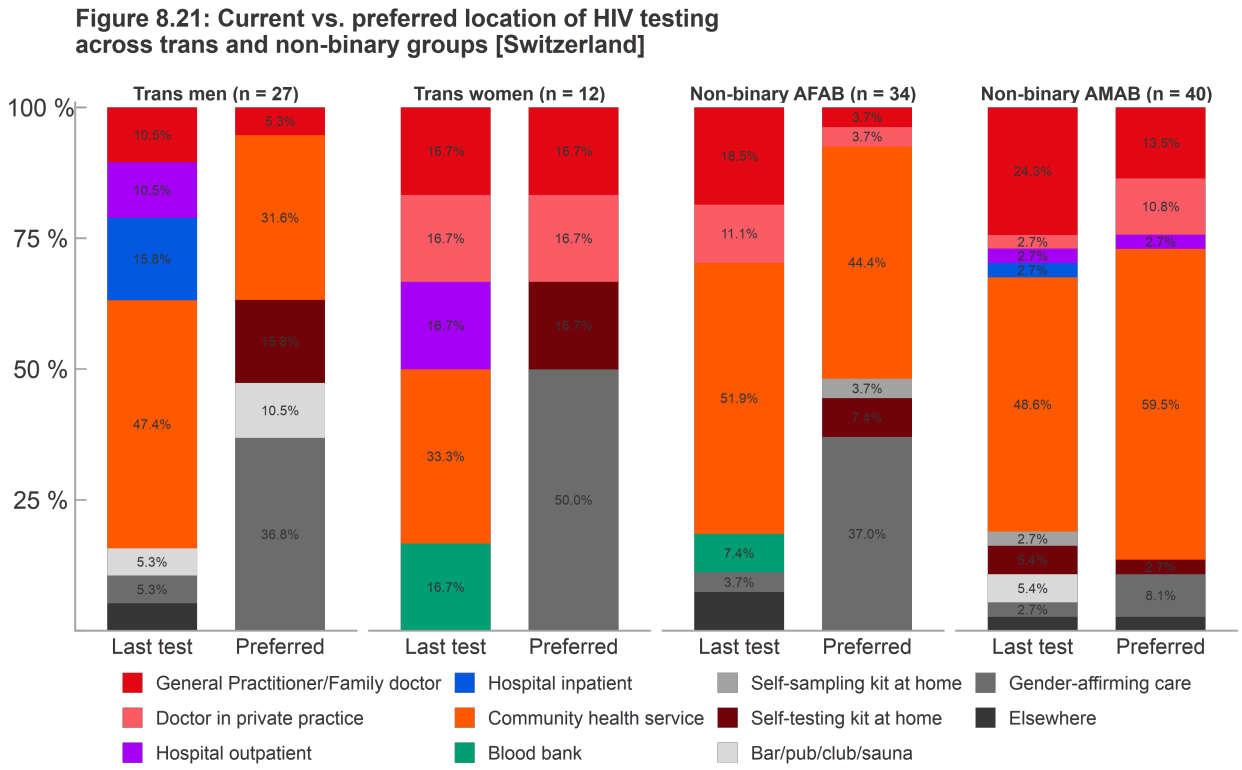
Overall, 17.4 % had ever been offered an HIV test by a health care service, with non-binary AMAB being the most likely to be offered a test among the four transgender groups (33.3 %). Around four out of five of trans and non-binary respondents (79.6 %) had ever received an HIV test result, although it was generally more common among Non-binary AMAB (92.5 %) and non-binary AFAB (79.4 %)

Around one in twelve had ever been forced or tricked into getting an HIV test (8 %) and on average, 27.4 % of our sample never had an STI test, while 52.2 % had an STI test in the last 12 months.

Respondents who indicated *"Ever"* in taken an HIV test, then they were asked: *"Where did you go for your last HIV test?"* and *"What would be your first choice for HIV testing, if you could choose freely?"*.

Figure 8.21 compares the responses to these two questions.

Figure 8.21: Current vs. preferred location of HIV testing across transgender groups



Getting an HIV test in/at… (the most recent and preferred location):

- **Community health centre**: 48.3 % indicated it as their *most recent* testing location, and 44.9 % as their *preferred* testing location.
- **Hospital as an outpatient**: 4.5 % indicated it as their *most recent* testing location, and 1.1 % indicated it as their *preferred* testing location.
- **General Practitioner/Family doctor**: 19.1 % indicated it as their *most recent* testing location, and 9 % *preferred* testing location.

Study participants who had been diagnosed with HIV were asked: *"When you were diagnosed HIV positive, how satisfied were you with the support and information you received?"** (n = 1) and study participants whose last HIV test was negative were asked: *"The last time you tested for HIV, how satisfied were you with the support and information you received?"* (n = 89, missing n = 24). Both were offered the responses in **Table 8.26**.

Table 8.26: Satisfaction with support and information received during HIV testing

Satisfaction with support and information received during HIV testing	Last HIV test was negative* N = 146	Diagnosed HIV** N = 1209
Very dissatisfied	100	1.1
I did not receive any support or information		18.0
Very satisfied		39.3
Satisfied		24.7
Dissatisfied		2.2
I don't remember / I did not think about it		14.6
Total	**100**	**100**

* Missing n = 0; ** Missing n = 0

Around two out of three trans and non-binary respondents were at least satisfied (63.3 %) with the amount of support they received. However, 17.8 % of trans and non-binary respondents did not receive any support or information. Overall, rates of dissatisfaction are higher in trans and non-binary respondents who tested negative (3.3 %) than in those who tested positive (1.1 %).

8.5.3.3 Elements of STI testing

Study participants who had an STI test in the last 12 months were asked to respond to the following:

"*So we can ask appropriate questions about your sexual life, and because people's bodies differ, please let us know if you have… (tick all that apply)*" with different options for people who were assigned female at birth ("*A vagina*"; "*A vulva with no vaginal opening*"; "*A penis (metoidioplasty)*"; "*A penis (phalloplasty)*"), and people who were assigned male at birth ("*A penis*", "*Testicles*", "*A (neo)vagina*", "*A (neo)vulva with no vaginal depth (without vaginal opening)*"). Then they were asked a series of questions (appropriate to their sexual characteristics) about what elements of an STI screening they had experienced in the last year.

Questions included:

- "*Was something inserted into the opening of your penis (urethral swab) as part of any STI test?*"
- "*Has your penis been examined as part of any STI test?*"
- "*Was something inserted into your vagina (vaginal swab) as part of any STI test?*"
- "*Has your vagina been examined as part of any STI test*"
- "*Was something inserted into your anus (anal swab) as part of any STI test?*"
- "*Has your anus been examined as part of any STI test?*"

The responses are summarised in **Table 8.27**.

Table 8.27: Elements of STI testing experienced in the last 12 months

Elements of STI testing in the last 12 months	% of trans men	% of trans women	% of non-binary AFAB	% of non-binary AMAB
Urethral swab[a] n = 14		0.0		63.6
Penis examination[b] n = 7		33.3		0.0
Vaginal swab[c] n = 28	92.3	100.0	92.9	
Vagina examination[d] n = 28	38.5	100.0	50.0	
Anal swab[e] n = 59	76.9	25.0	56.2	76.9
Anus examination[f] n = 58	7.7	0.0	0.0	26.9

[a] Missing n = 0; [b] Missing n = 0; [c] Missing n = 0; [d] Missing n = 0; [e] Missing n = 0; [f] Missing n = 1

Among transgender men, the most common component of STI testing in the last 12 months was a vaginal swab (92.3 %), followed by an anal swab (76.9 %). Less common were vaginal (38.5%) and anus examinations (7.7 %).

All 28 transgender women with a vagina reported a vaginal swab and a vaginal examination as part of STI-testing.

Among non-binary AFAB individuals, the majority received a vaginal swab (92.9 %) and an anal swab (56.2 %).

Most non-binary AMAB respondents had received an anal (76.9 %) and urethral swab (63.6% %) as part of STI testing.

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Chapter 9: Health inequalities

This chapter asks, *"What are the levels of (1) sexual morbidities, (2) risk and precaution behaviour, (3) unmet prevention needs and (4) use of interventions, across the varied groups of MSM in the populations that are targets for sexual health promotion?"* To do this we consider how the binary indicators described in **Chapters 4** to **7** vary across key target groups for sexual health promotion identified in **Chapter 3**.

We take this descriptive approach to facilitate access to data that can address the many specific questions EMIS data users may have. Our partners and stakeholders have many different health concerns about a wide range of sub-populations of (mainly) MSM. This chapter provides data more tailored to their concerns. For example, the chapter shows the percentage of respondents with diagnosed HIV experiencing anxiety/depression, or the percent of respondents under 25 years who do not have access to condoms.

Each sub-chapter begins with a demographic overview of the groups presented, allowing differences between groups to be properly contextualised.

We then look at the indicators across six key demographics: age; sexual and gender identity; 'outness'; relationship status; migration status; and HIV diagnosis. We also consider two minority groups (MSM injecting drugs; MSM selling sex) using the same set of indicators. We provide data on total of 64 binary health indicators: 13 morbidity indicators; 10 behaviour indicators; 22 needs indicators; and 19 intervention indicators.

We provide these binary indicators for a total of 28 groups: 4 age groups; 6 groups based on sexual and gender identity; 3 groups based on the level of outness; 3 groups based on relationship status; 4 migrancy status groups; 2 groups based on HIV diagnosis; 4 selling sex groups; and 2 injecting groups. In total, this chapter supplies 1792 measures. The chapter also considers the question *"Which subgroups of respondents have multiple prevention needs that are poorly met and should be priority target groups?"* In all subsequent tables shading indicates the sub-group in which the indicator is most extreme. This highlights the sub-group with most morbidity, most risk behaviour or least precaution behaviour, greatest unmet health promotion needs, least experience of interventions to improve health and most experience of health-diminishing interventions. Columns with many highlighted cells indicate sub-groups with consistently greater morbidities, higher risks, lower precautions, greater unmet needs and less experience of interventions relative to other sub-groups. This allows for identification of priority groups in terms of those characteristics.

Our approach to data presentation is descriptive rather than statistical. We have not calculated the probabilities of these observed differences being random as this is a non-probability sample. We have not provided unadjusted associations (*e.g.*, odds ratios, risk ratios) between the demographic target groups and the indicators as these can be calculated from the data in the tables. We have not provided adjusted associations between the demographic target groups and the indicators (*i.e.*, controlling for membership of the other demographic target groups) as we are not asking questions about the causality of these associations but describing the levels of the many indicators in the myriad target groups.

In the tables below, where the denominator for a cell is fewer than 20, we have not supplied the figure and instead the cell contains the characters "n < 20".

9.1 Age inequalities

The age profile of the sample is described in **Section 3.2**. The tables below present key demographics and key indicators by age group.

Table 9.1 Key demographics by age group

Age groups and demographics	< 25 (n = 128)	25–39 (n = 459)	40–64 (n = 791)	65+ (n = 131)	All (N = 1509)
Age (mean)	21.4	32.2	51.3	70.1	44.6
Age (SD)	2.1	4.1	7.0	4.7	14.3
Age (median)	22	33	52	69	44
% with higher education	29.7	70.5	64.6	64.9	63.5
% with current steady partner	28.1	46.2	56.9	53.4	50.9
% fully out[a]	44.5	56.6	55.9	45.0	54.2
% born abroad	21.9	31.2	31.1	8.4	28.4
% sex workers[b]	3.1	2.6	1.3	0.8	1.8
% PWID[c]	0.0	1.3	2.7	2.3	2.0

[a] all/almost all know about sexual attraction to men; [b] sold sex 3+ times, last 12m; [c] People who inject drugs (excluding steroids), last 12m

Respondents under the age of 25 had the lowest proportion reporting a steady partner (28.1 %) and the highest proportion engaged in frequent sex work (3.1 %). Those aged 40–64 had the highest proportion of people who inject drugs (PWID; 2.7 %).

9.1.1 Age and morbidities

The levels of morbidities varied for different age groups. Younger respondents (under 25 years) were more likely to report mental health morbidities (anxiety/depression and suicidal thoughts) and sexual unhappiness. Alcohol dependency was most common in the 25–39-years-olds, as was acquisition of several STIs. Having HIV was most common in the 40–64-year-olds but having detectable HIV was more common in those under the age of 25.

Table 9.2 Key morbidities by age group

Age groups and morbidities	< 25 (n = 128)	25–39 (n = 459)	40–64 (n = 791)	65+ (n = 131)	All (N = 1509)
% with severe anxiety and depression[a]	11.0	6.4	3.8	0.8	5.0
% with self-harm thoughts[a]	25.8	16.1	14.5	12.2	15.8
% sexually unhappy[b]	18.0	16.3	14.0	14.5	15.1
% with potential alcohol dependency[c]	20.3	23.4	17.8	15.3	19.5
% diagnosed with HIV, ever	0.8	3.7	13.8	15.4	9.8
% diagnosed with HIV, last 12m	0.0	0.2	0.1	0.0	0.1
% with detectable viral load[d]	n < 20	n < 20	0.9	0.0	0.7
% with active hepatitis B or C	0.0	0.0	0.4	0.8	0.3
% diagnosed with mpox[e]	0.0	0.7	1.1	0.0	0.8
% diagnosed with syphilis[f]	3.1	7.4	6.6	4.6	6.4
% diagnosed with gonorrhoea[f]	8.6	18.5	13.0	3.1	13.5
% diagnosed with chlamydia[f]	5.5	15.7	12.5	8.4	12.5
% diagnosed with anal/genital warts[g]	0.8	14.2	22.9	15.4	17.7

[a] last two weeks; [b] scoring less than 5 on the 1 to 10 scale; [c] last two weeks (PHQ-4); [d] among HIV-diagnosed; [e] since 2022; [f] last 12 months; [g] ever

9.1.2 Age and behaviour

Precautionary behaviour was least common in the youngest group, risky behaviour was most common in the age group 40–65, including number of non-steady male sex partners and sexual repertoire [1]. Precautionary behaviour (taking ART and PrEP) was most common in the age group with most risk behaviour.

Table 9.3 Key behaviour by age groups

Age groups and behaviours	< 25 (n = 128)	25–39 (n = 459)	40–64 (n = 791)	65+ (n = 131)	All (N = 1509)
% engaging in safer sex[a]	27.3	52.1	59.8	42.0	53.1
% using condoms consistently[b]	32.9	23.2	23.4	15.3	23.3
% taking PrEP[c]	7.8	32.7	30.5	17.6	28.1
% taking ART[d]	n < 20	n < 20	91.7	75.0	89.7
% who ever took HIV-PEP[c]	5.5	14.6	16.3	6.9	14.0
% using antibiotics for STI prophylaxis[e]	1.6	8.1	9.2	6.1	8.0
Number (median) of NON-STEADY male sex partners	2	6	7	4	6
Sexual Repertoire Score (mean)[f]	5.2	6.1	6.3	5.7	6.1
% engaging in chemsex[g]	1.6	4.6	7.3	3.8	5.7
% injecting drugs[h]	0.0	1.3	2.7	2.3	2.0

[a] consistent condom or PrEP use or undetectable viral load; [b] consistent condom use with NON-STEADY male intercourse partners; [c] excluding HIV-diagnosed; [d] among HIV-diagnosed; [e] took antibiotics in the last 12 months, '(e.g., doxycycline) before or after having sex to reduce the risk of getting some sexually transmitted infections. (Doxy PrEP/Doxy-PEP)'; [f] The Sexual Repertoire Score (SRS) is an additive score ranging from 1 to 9, based on previous-12-months engagement in 9 sexual practices with NON-STEADY male partners.; [g] defined as using stimulant drugs to make sex more intense or last longer, last 4 weeks; [h] excluding steroids, last 12 months

9.1.3 Age and unmet prevention needs

Respondents under 25 years reported higher levels of unmet prevention needs for most indicators. Exceptions included concerns about drug use, which were most common among respondents on PrEP; knowledge and decision-making needs, which were greater among older participants; and concerns about sexual and drug safety, which were most pronounced among those aged 25–39 years.

Table 9.4 Key needs by age groups

Age groups and needs	< 25 (n = 128)	25–39 (n = 459)	40–64 (n = 791)	65+ (n = 131)	All (N = 1509)
Score (mean) for the SIHS (0–6)[a]	1.3	1.2	1.0	0.9	1.1
% concerned about own drug use	7.0	4.6	5.2	0.0	4.7
% lacking control over safer sex	12.5	11.3	8.1	8.4	9.5
% lacking control over unwanted sex	14.8	10.7	5.9	8.4	8.3
% experiencing homo- or transnegative violence[b]	2.3	2.6	2.1	0.0	2.1
% experiencing physically forced or coerced to have sex[b]	4.7	2.6	0.9	0.0	1.7
% experienced stigma in healthcare facilities[b]	13.3	10.2	4.4	1.5	6.7
% anticipated stigma in healthcare facilities[b]	24.2	12.6	6.1	3.1	9.3
% feeling unsafe in public spaces[b]	53.1	34.0	14.3	4.6	22.7
Number (mean) of unknown HIV/STI transmission facts (0–6)	1.7	1.5	1.8	2.4	1.8
% not knowing U=U[c]	24.2	9.4	12.7	23.1	13.6
Number (mean) of unknown PrEP facts (0–6)	2.0	1.7	1.8	2.0	1.8
% unaware of PrEP	29.9	13.2	14.2	26.4	16.4
Number (mean) of unknown HIV test/treat facts (0–7)	1.7	1.7	1.5	1.7	1.6
% not knowing where to test for HIV	11.7	3.1	0.5	3.8	2.5
Number (mean) of unknown hepatitis facts (0–5)	1.8	1.7	1.7	1.7	1.7
% not knowing where to get hepatitis A/B vaccination	13.3	8.3	8.5	13.0	9.2
Number (mean) of unknown HPV facts (0–3)	2.0	1.9	2.1	2.5	2.1
% not knowing that HPV vaccine exists	28.3	21.9	37.4	62.0	34.0
Number (mean) of unknown mpox facts (0–3)	1.9	1.7	2.0	2.1	1.9
% not knowing that mpox vaccine exists	22.9	14.8	14.9	30.8	16.9
% not knowing where to get mpox vaccination	59.5	27.7	25.7	34.6	29.9

[a] Short Internalised Homonegativity Scale; [b] last 12 months; [c] a person with undetectable viral load cannot pass on HIV sexually

These data highlight specific and actionable needs among the youngest segment of the MSM population across Switzerland. While the behavioural data suggest they may, as yet, not be engaging in sexual risk behaviour to the same extent as older respondents, they show levels of need that can only expose them to significant risk of future sexual ill health. In this age group, 12.5 % reported a lack of control over safer sex, 14.8 reported lack of control over unwanted sex; and 4.7 % reported having been physically forced or coerced to have sex in the last 12 months.

A high proportion of those under 25 do not know what PrEP is (29.9 %). Half (24.2 %) do not know that a person with undetectable viral load cannot pass on HIV (U=U) and a similar number (11.7 %) do not know where to test for HIV. Finally, 13.3 % did not know where to get hepatitis A/B vaccination, 28.3 % did not know that HPV vaccine exists, and 59.5 % did not know where to get mpox vaccination. Failure to meet these relatively simple needs related to information and the provision of services, along with failure to promote them appropriately, can only exacerbate future sexual health morbidities.

9.1.4 Age and interventions

The youngest and oldest age groups were least likely to report encountering or accessing interventions. While HIV prevalence increases with age, and new diagnoses were most common among the 25–39 age group, those under 25-year-olds with diagnosed HIV were least likely to have ever had their HIV infection monitored ('Linked to care'; HIV care cascade stage 3); to have had it monitored in the last six months ('Retained in care' HIV care cascade stage 4); and to have an undetectable viral load (HIV care cascade stage 6). Respondents under 25 years of age were the least likely to report hepatitis A or a hepatitis B vaccination; or to have received an anal swab in the past 12 months. However, consistent with most national guidelines, they had the highest proportion with at least one dose of HPV vaccine (49.2 %).

Table 9.5 Key interventions by age group

Age groups and interventions	< 25 (n = 128)	25–39 (n = 459)	40–64 (n = 791)	65+ (n = 131)	All (N = 1509)
% saw or heard MSM-specific information about HIV or STIs[a]	89.1	92.2	91.9	88.5	91.5
% offered hepatitis vaccination by health service[b]	72.7	78.4	72.9	64.1	73.8
% with full course of HAV vaccination[c]	50.0	69.6	73.7	58.8	69.1
% with full course of HBV vaccination[d]	65.6	76.4	72.0	61.0	71.9
% with at least one shot of HPV vaccine	49.2	32.7	11.5	4.6	20.5
% with at least one shot of mpox vaccine[e]	12.7	36.0	35.5	23.8	32.7
% who received free condoms[af]	37.5	37.7	34.6	29.8	35.4
% spoken to about PrEP at a health service[g]	39.4	54.9	50.5	33.0	49.5
% tested for HIV[ah]	61.7	71.5	59.9	45.8	62.4
% using community HIV-testing at last HIV test	47.8	54.1	37.1	26.7	42.1
% using self-sampling at last HIV test	1.1	2.2	0.8	0.9	1.2
% using self-testing at last HIV test	4.3	4.9	2.5	3.4	3.4
% linked to care (HIV care cascade stage 3)[i]	n < 20	n < 20	100.0	100.0	100.0
% retained in care (HIV care cascade stage 4)[i]	100.0	100.0	100.0	100.0	100.0
% on ART (HIV care cascade stage 5)[i]	100.0	100.0	100.0	100.0	100.0
% virally suppressed (HIV care cascade stage 6)[i]	100.0	100.0	99.0	100.0	99.2
% tested for STIs[a]	54.7	72.5	65.1	53.4	65.5
% receiving anal swabbing[a]	40.6	60.1	49.4	35.9	50.8
% with substance use counselling / self-support group[a]	0.0	2.5	1.3	1.8	1.6

[a] last 12 months; [b] ever; [c] excluding respondents with past hepatitis A; [d] excluding respondents with past hepatitis B; [e] excluding respondents with past mpox; [f] from civil society organisations, clinic, bars, or saunas; [g] excluding HIV-diagnosed; [h] excluding respondents diagnosed prior to that; [i] among HIV-diagnosed

9.2 Gender identity and sex at birth (cis and trans) inequalities

Section 3.1 describes how combinations of sex at birth and current gender identity were distributed across the sample. Trans respondents, particularly trans men, and non-binary respondents were substantially younger than cis MSM, and hence lower proportions with higher education. Cis MSM who don't identify as gay or bisexual were less likely than all other groups to be 'out' about their attraction to men (32.5 %), and less likely to report a steady partnership (39 %).

Table 9.6 Key demographics by sex and gender group

Sex and gender groups and demographics	Cis gbMSM (n = 1316)	Cis non-gb MSM (n = 77)	Trans men (n = 27)	Trans women (n = 12)	Non-binary AFAB (n = 34)	Non-binary AMAB (n = 40)	All (N = 1506)
Age (mean)	45.9	44.4	26.9	36.0	27.8	33.5	44.6
Age (SD)	13.9	14.7	9.4	n < 20	6.6	14.0	14.4
Age (median)	46	46	25	32	26	28	44
% with higher education	64.1	66.2	59.3	n < 20	50.0	50.0	63.5
% with current steady partner	52.5	39.0	37.0	n < 20	50.0	40.0	51.0
% fully out[a]	56.3	32.5	59.3	n < 20	38.2	50.0	54.3
% born abroad	28.5	35.5	37.0	n < 20	17.6	22.5	28.4
% sex workers[b]	1.7	1.3	3.7	n < 20	2.9	2.5	1.8
% PWID[c]	2.2	1.3	0.0	n < 20	0.0	0.0	2.0

[a] all/almost all know about sexual attraction to men; [b] sold sex 3+ times, last 12m; [c] People who inject drugs (excluding steroids), last 12m

9.2.1 Sex/gender and morbidities

Poor mental health and substance dependency were higher in trans and non-binary groups, while infections were more common among cis MSM, particularly in those identifying as gay or bisexual. Anxiety/depression and suicidal ideation were significantly high among trans men and non-binary respondents.

Table 9.7 Key morbidities by sex and gender group

Sex and gender groups and morbidities	Cis gbMSM (n = 1316)	Cis non-gb MSM (n = 77)	Trans men (n = 27)	Trans women (n = 12)	Non-binary AFAB (n = 34)	Non-binary AMAB (n = 40)	All (N = 1506)
% with severe anxiety and depression[a]	3.8	5.3	7.4	n < 20	29.4	12.5	5.0
% with self-harm thoughts[a]	13.4	20.8	37.0	n < 20	50.0	37.5	15.8
% sexually unhappy[b]	14.2	16.9	25.9	n < 20	20.6	27.5	15.1
% with potential alcohol dependency[c]	18.5	23.4	22.2	n < 20	35.3	35.0	19.5
% diagnosed with HIV, ever	10.9	3.9	0.0	n < 20	0.0	0.0	9.8
% diagnosed with HIV, last 12m	0.2	0.0	0.0	n < 20	0.0	0.0	0.1
% with detectable viral load[d]	0.7	n < 20	-	n < 20	-	-	0.7
% with active hepatitis B or C	0.3	0.0	0.0	n < 20	0.0	0.0	0.3
% diagnosed with mpox[e]	0.9	0.0	0.0	n < 20	0.0	0.0	0.8
% diagnosed with syphilis[f]	6.9	2.6	3.7	n < 20	0.0	5.0	6.4
% diagnosed with gonorrhoea[f]	14.6	9.1	0.0	n < 20	8.8	2.5	13.5
% diagnosed with chlamydia[f]	13.3	9.1	0.0	n < 20	8.8	10.0	12.5
% diagnosed with anal/genital warts[g]	18.8	15.6	3.7	n < 20	5.9	7.5	17.8

[a] last two weeks; [b] scoring less than 5 on the 1 to 10 scale; [c] last two weeks (PHQ-4); [d] among HIV-diagnosed; [e] since 2022; [f] last 12 months; [g] ever

9.2.2 Sex/gender and behaviour

Among trans and non-binary responds, engaging in safer sex was less common than in cis MSM who identify as gay or bisexual. Gay and bisexual cis MSM also reported higher number of non-steady male sex partner than other cis MSM or trans and non-binary respondents. PrEP use was particularly common in gay/bisexual cis MSM. However, trans women were much more likely to engage in chemsex.

Table 9.8 Key behaviour by sex and gender group

Sex and gender groups and behaviours	Cis gbMSM (n = 1316)	Cis non-gb MSM (n = 77)	Trans men (n = 27)	Trans women (n = 12)	Non-binary AFAB (n = 34)	Non-binary AMAB (n = 40)	All (N = 1506)
% engaging in safer sex[a]	56.1	39.0	18.5	n < 20	14.7	50.0	53.2
% using condoms consistently[b]	22.6	25.6	n < 20	n < 20	n < 20	35.7	23.3
% taking PrEP[c]	29.8	22.1	7.4	n < 20	5.9	25.0	28.1
% taking ART[d]	89.4	n < 20	-	n < 20	-	-	89.7
% who ever took HIV-PEP[c]	14.8	13.0	0.0	n < 20	5.9	12.5	14.1
% using antibiotics for STI prophylaxis[e]	8.4	10.4	0.0	n < 20	2.9	0.0	8.0
Number (median) of NON-STEADY male sex partners	7	3	0	0	0	3	6
Sexual Repertoire Score (mean)[f]	6.2	5.9	4.8	5.0	3.7	5.6	6.1
% engaging in chemsex[g]	6.0	5.2	3.7	n < 20	2.9	2.5	5.7
% injecting drugs[h]	2.2	1.3	0.0	n < 20	0.0	0.0	2.0

[a] consistent condom or PrEP use or undetectable viral load; [b] consistent condom use with NON-STEADY male intercourse partners; [c] excluding HIV-diagnosed; [d] among HIV-diagnosed; [e] took antibiotics in the last 12 months, '(e.g., doxycycline) before or after having sex to reduce the risk of getting some sexually transmitted infections. (Doxy PrEP/Doxy-PEP)'; [f] The Sexual Repertoire Score (SRS) is an additive score ranging from 1 to 9, based on previous-12-months engagement in 9 sexual practices with NON-STEADY male partners.; [g] defined as using stimulant drugs to make sex more intense or last longer, last 4 weeks; [h] excluding steroids, last 12 months

9.2.3 Sex/gender and needs

For nearly every indicator of need, trans men and women——as well as cis MSM who did not identify as gay or bisexual——reported the highest levels of unmet needs. Trans men and women were particularly likely to experience homo-/transphobic violence, rape, or stigma within healthcare settings.

Table 9.9 Key needs by sex and gender group

Sex and gender groups and needs	Cis gbMSM (n = 1316)	Cis non-gb MSM (n = 77)	Trans men (n = 27)	Trans women (n = 12)	Non-binary AFAB (n = 34)	Non-binary AMAB (n = 40)	All (N = 1506)
Score (mean) for the SIHS (0–6)[a]	1.0	1.5	-	-	-	-	1.1
% concerned about own drug use	4.6	5.2	3.7	n < 20	8.8	7.5	4.7
% lacking control over safer sex	9.3	2.6	0.0	n < 20	29.4	15.0	9.4
% lacking control over unwanted sex	7.5	7.8	22.2	n < 20	35.3	5.0	8.4
% experiencing homo- or transnegative violence[b]	2.1	3.9	0.0	n < 20	0.0	2.5	2.1
% experiencing physically forced or coerced to have sex[b]	1.4	1.3	3.7	n < 20	8.8	2.5	1.7
% experienced stigma in healthcare facilities[b]	4.5	9.1	44.4	n < 20	50.0	7.5	6.7
% anticipated stigma in healthcare facilities[b]	6.2	15.6	66.7	n < 20	55.9	10.0	9.3
% feeling unsafe in public spaces[b]	20.8	23.4	55.6	n < 20	64.7	22.5	22.7
Number (mean) of unknown HIV/STI transmission facts (0–6)	1.8	1.7	1.0	2.0	1.8	1.6	1.8
% not knowing U=U[c]	11.8	30.3	22.2	n < 20	20.6	20.0	13.5
Number (mean) of unknown PrEP facts (0–6)	1.7	2.2	2.0	2.2	2.1	2.2	1.8
% unaware of PrEP	13.0	39.2	37.0	n < 20	38.2	32.5	16.4
Number (mean) of unknown HIV test/treat facts (0–7)	1.5	2.0	2.1	2.2	1.5	1.8	1.6
% not knowing where to test for HIV	1.7	6.5	7.4	n < 20	5.9	5.0	2.5
Number (mean) of unknown hepatitis facts (0–5)	1.7	1.9	1.9	1.0	1.0	1.0	1.7
% not knowing where to get hepatitis A/B vaccination	8.4	14.3	11.1	n < 20	17.6	7.5	9.2
Number (mean) of unknown HPV facts (0–3)	2.1	2.3	1.8	1.8	1.7	2.2	2.1
% not knowing that HPV vaccine exists	33.6	42.7	22.2	n < 20	26.5	37.5	33.9
Number (mean) of unknown mpox facts (0–3)	1.9	2.2	1.8	2.1	1.9	2.0	1.9
% not knowing that mpox vaccine exists	15.4	29.9	24.0	n < 20	31.2	n < 20	16.9
% not knowing where to get mpox vaccination	26.9	49.4	55.6	n < 20	52.9	42.5	29.9

[a] Short Internalised Homonegativity Scale; [b] last 12 months; [c] a person with undetectable viral load cannot pass on HIV sexually

9.2.4 Sex/gender and interventions

Access to all the positive interventions was generally lower in the trans groups than among cis MSM with a gay or bisexual identity.

Table 9.10 Key interventions by sex and gender group

Sex and gender groups and interventions	Cis gbMSM (n = 1316)	Cis non-gb MSM (n = 77)	Trans men (n = 27)	Trans women (n = 12)	Non-binary AFAB (n = 34)	Non-binary AMAB (n = 40)	All (N = 1506)
% saw or heard MSM-specific information about HIV or STIs[a]	92.9	79.2	92.6	n < 20	91.2	77.5	91.4
% offered hepatitis vaccination by health service[b]	75.2	63.6	63.0	n < 20	64.7	72.5	73.8
% with full course of HAV vaccination[c]	72.2	52.0	48.1	n < 20	27.3	68.4	69.2
% with full course of HBV vaccination[d]	73.7	60.0	63.0	n < 20	52.9	71.8	71.9
% with at least one shot of HPV vaccine	19.6	11.7	51.9	n < 20	41.2	32.5	20.6
% with at least one shot of mpox vaccine[e]	34.7	18.2	7.4	n < 20	11.8	37.5	32.7
% who received free condoms[af]	35.5	27.3	29.6	n < 20	47.1	45.0	35.5
% spoken to about PrEP at a health service[g]	52.5	39.2	22.2	n < 20	20.6	37.5	49.5
% tested for HIV[ah]	63.9	48.1	48.1	n < 20	44.1	75.0	62.4
% using community HIV-testing at last HIV test	41.7	36.5	n < 20	n < 20	51.9	54.1	42.1
% using self-sampling at last HIV test	1.2	1.6	n < 20	n < 20	0.0	2.7	1.2
% using self-testing at last HIV test	3.5	3.2	n < 20	n < 20	0.0	5.4	3.4
% linked to care (HIV care cascade stage 3)[i]	100.0	n < 20	-	n < 20	-	-	100.0
% retained in care (HIV care cascade stage 4)[i]	100.0	100.0	-	100.0	-	-	100.0
% on ART (HIV care cascade stage 5)[i]	100.0	100.0	-	100.0	-	-	100.0
% virally suppressed (HIV care cascade stage 6)[i]	99.2	100.0	-	100.0	-	-	99.2
% tested for STIs[a]	67.3	53.2	48.1	n < 20	47.1	65.0	65.5
% receiving anal swabbing[a]	53.0	35.1	37.0	n < 20	26.5	50.0	50.8
% with substance use counselling / self-support group[a]	1.6	3.1	n < 20	n < 20	n < 20	0.0	1.6

[a] last 12 months; [b] ever; [c] excluding respondents with past hepatitis A; [d] excluding respondents with past hepatitis B; [e] excluding respondents with past mpox; [f] from civil society organisations, clinic, bars, or saunas; [g] excluding HIV-diagnosed; [h] excluding respondents diagnosed prior to that; [i] among HIV-diagnosed

9.3 'Outness' inequalities

The extent to which respondents were open about their attraction to men is reported in **Section 3.7**. Below we compare indicators across three 'outness' groups based on the proportion of respondents' family, friends and work colleagues who knew of their attraction to men: none or few (19.8 %); some (24.5 %) and all or almost all (54.2 %).

Table 9.11 Key demographics by 'outness' group

Outness groups and demographics	None or few (n = 299)	Some know (n = 369)	All or almost all (n = 818)	All (N = 1486)
Age (mean)	47.5	42.2	44.4	44.5
Age (SD)	15.2	14.8	13.6	14.3
Age (median)	48	40	44	44
% with higher education	64.1	61.1	64.5	63.6
% with current steady partner	41.5	37.1	60.8	51.0
% born abroad	24.5	32.0	28.2	28.4
% sex workers[b]	2.3	0.8	2.1	1.8
% PWID[c]	0.7	2.5	2.3	2.0

[b] sold sex 3+ times, last 12m; [c] People who inject drugs (excluding steroids), last 12m

9.3.1 ‘Outness’ and morbidities

Sexual unhappiness, poor mental health, and poorly treated HIV were more common in respondents with few or no acquaintances aware of their attraction to men. Conversely, the respondents who were out were more likely to experience alcohol dependency and a range of infections.

Table 9.12 Key morbidities by ‘outness’ group

Outness groups and morbidities	None or few (n = 299)	Some know (n = 369)	All or almost all (n = 818)	All (N = 1486)
% with severe anxiety and depression[a]	3.0	6.1	5.2	5.0
% with self-harm thoughts[a]	14.4	18.4	15.0	15.7
% sexually unhappy[b]	19.9	15.4	12.9	14.9
% with potential alcohol dependency[c]	14.7	21.2	20.2	19.3
% diagnosed with HIV, ever	3.7	10.6	11.9	9.9
% diagnosed with HIV, last 12m	0.0	0.6	0.0	0.2
% with detectable viral load[d]	n < 20	0.0	0.0	0.7
% with active hepatitis B or C	0.3	0.3	0.2	0.3
% diagnosed with mpox[e]	0.3	0.8	1.0	0.8
% diagnosed with syphilis[f]	5.0	5.7	7.4	6.5
% diagnosed with gonorrhoea[f]	7.4	11.9	16.6	13.6
% diagnosed with chlamydia[f]	9.4	10.8	14.8	12.7
% diagnosed with anal/genital warts[g]	10.7	15.6	21.2	17.7

[a] last two weeks; [b] scoring less than 5 on the 1 to 10 scale; [c] last two weeks (PHQ-4); [d] among HIV-diagnosed; [e] since 2022; [f] last 12 months; [g] ever

9.3.2 ‘Outness’ and behaviour

Sexual risk behaviour and sexual precautions, as well as injection drug use were more common in the respondents who were out than those who were not out. Respondents who were not out were less likely to use ART if they had HIV, or PrEP if they did not.

Table 9.13 Key behaviour by ‘outness’ group

Outness groups and behaviours	None or few (n = 299)	Some know (n = 369)	All or almost all (n = 818)	All (N = 1486)
% engaging in safer sex[a]	41.8	54.5	57.9	53.8
% using condoms consistently[b]	30.8	26.4	19.5	23.4
% taking PrEP[c]	18.4	25.7	33.3	28.4
% taking ART[d]	n < 20	89.7	89.6	89.7
% who ever took HIV-PEP[c]	7.4	13.3	17.1	14.2
% using antibiotics for STI prophylaxis[e]	4.3	7.3	9.8	8.1
Number (median) of NON-STEADY male sex partners	4	6	7	6
Sexual Repertoire Score (mean)[f]	5.8	6.0	6.3	6.1
% engaging in chemsex[g]	3.3	3.8	7.3	5.7
% injecting drugs[h]	0.7	2.5	2.3	2.0

[a] consistent condom or PrEP use or undetectable viral load; [b] consistent condom use with NON-STEADY male intercourse partners; [c] excluding HIV-diagnosed; [d] among HIV-diagnosed; [e] took antibiotics in the last 12 months, '(e.g., doxycycline) before or after having sex to reduce the risk of getting some sexually transmitted infections. (Doxy PrEP/Doxy-PEP'; [f] The Sexual Repertoire Score (SRS) is an additive score ranging from 1 to 9, based on previous-12-months engagement in 9 sexual practices with NON-STEADY male partners.; [g] defined as using stimulant drugs to make sex more intense or last longer, last 4 weeks; [h] excluding steroids, last 12 months

9.3.3 'Outness' and needs

In contrast to risk behaviour, for almost all indicators, unmet need was more common in respondents who were out to fewer people. Respondents who were out to few people or no-one knew less, had less confidence, less access, less support and more concerns.

Table 9.14 Key needs by 'outness' group

Outness groups and needs	None or few (n = 299)	Some know (n = 369)	All or almost all (n = 818)	All (N = 1486)
Score (mean) for the SIHS (0–6)[a]	2.0	1.2	0.7	1.0
% concerned about own drug use	2.0	4.9	5.7	4.8
% lacking control over safer sex	11.4	11.1	8.1	9.5
% lacking control over unwanted sex	8.4	11.7	7.0	8.4
% experiencing homo- or transnegative violence[b]	0.7	1.6	2.9	2.2
% experiencing physically forced or coerced to have sex[b]	1.3	2.2	1.6	1.7
% experienced stigma in healthcare facilities[b]	5.4	7.6	6.8	6.7
% anticipated stigma in healthcare facilities[b]	17.1	11.7	5.4	9.3
% feeling unsafe in public spaces[b]	15.4	25.5	24.4	22.9
Number (mean) of unknown HIV/STI transmission facts (0–6)	2.0	1.7	1.7	1.8
% not knowing U=U[c]	25.2	13.9	8.1	13.0
Number (mean) of unknown PrEP facts (0–6)	2.0	1.8	1.7	1.8
% unaware of PrEP	28.3	15.2	10.9	15.7
Number (mean) of unknown HIV test/treat facts (0–7)	1.8	1.6	1.4	1.6
% not knowing where to test for HIV	6.4	3.0	0.9	2.5
Number (mean) of unknown hepatitis facts (0–5)	1.8	1.7	1.7	1.7
% not knowing where to get hepatitis A/B vaccination	17.7	8.4	6.1	9.0
Number (mean) of unknown HPV facts (0–3)	2.3	2.0	2.1	2.1
% not knowing that HPV vaccine exists	45.2	33.4	29.1	33.4
Number (mean) of unknown mpox facts (0–3)	2.2	2.0	1.7	1.9
% not knowing that mpox vaccine exists	28.6	16.6	12.2	16.6
% not knowing where to get mpox vaccination	50.2	31.5	20.9	29.4

[a] Short Internalised Homonegativity Scale; [b] last 12 months; [c] a person with undetectable viral load cannot pass on HIV sexually

9.3.4 'Outness' and interventions

Despite being most likely to be in need, respondents who were not out were least likely to encounter or access interventions.

Table 9.15 Key interventions by 'outness' group

Outness groups and interventions	None or few (n = 299)	Some know (n = 369)	All or almost all (n = 818)	All (N = 1486)
% saw or heard MSM-specific information about HIV or STIs[a]	86.0	92.7	93.3	91.7
% offered hepatitis vaccination by health service[b]	59.5	73.4	79.8	74.2
% with full course of HAV vaccination[c]	57.0	65.2	75.7	69.3
% with full course of HBV vaccination[d]	60.5	69.2	78.1	72.3
% with at least one shot of HPV vaccine	8.0	22.2	24.8	20.8
% with at least one shot of mpox vaccine[e]	16.4	28.5	41.2	33.0
% who received free condoms[af]	28.1	34.4	38.6	35.5
% spoken to about PrEP at a health service[g]	32.9	52.1	55.8	50.0
% tested for HIV[ah]	57.2	61.0	65.0	62.4
% using community HIV-testing at last HIV test	37.7	44.2	43.1	42.4
% using self-sampling at last HIV test	1.6	1.2	1.0	1.2
% using self-testing at last HIV test	6.7	3.3	2.2	3.3
% linked to care (HIV care cascade stage 3)[i]	n < 20	100.0	100.0	100.0
% retained in care (HIV care cascade stage 4)[i]	100.0	100.0	100.0	100.0
% on ART (HIV care cascade stage 5)[i]	100.0	100.0	100.0	100.0
% virally suppressed (HIV care cascade stage 6)[i]	90.0	100.0	100.0	99.2
% tested for STIs[a]	45.8	65.9	73.1	65.8
% receiving anal swabbing[a]	31.8	49.9	59.2	51.3
% with substance use counselling / self-support group[a]	0.7	0.5	2.4	1.6

[a] last 12 months; [b] ever; [c] excluding respondents with past hepatitis A; [d] excluding respondents with past hepatitis B; [e] excluding respondents with past mpox; [f] from civil society organisations, clinic, bars, or saunas; [g] excluding HIV-diagnosed; [h] excluding respondents diagnosed prior to that; [i] among HIV-diagnosed

9.4 Partnership status inequalities

Section 3.8 reports on the extent of steady partnerships in the sample. Below we compare indicators for respondents who are single, have a steady partner (note that partners may be male, female, or non-binary, and may be multiple) and those who indicated *"I'm not sure/it's complicated"*.

Table 9.16 Key demographics by relationship status group

Relationship status groups and demographics	Single (n = 648)	Steady partner (n = 768)	Complicated (n = 93)	All (N = 1509)
Age (mean)	42.2	46.3	46.9	44.6
Age (SD)	14.7	13.5	16.2	14.3
Age (median)	42	46	51	44
% with higher education	57.5	68.4	64.1	63.5
% fully out	44.1	64.7	37.6	54.2
% born abroad	27.4	29.8	23.7	28.4
% sex workers[b]	2.3	1.4	1.1	1.8
% PWID[c]	1.6	2.1	4.3	2.0

[b] sold sex 3+ times, last 12m; [c] People who inject drugs (excluding steroids), last 12m

9.4.1 Partnership status and morbidities

Single respondents were a great deal more likely to be sexually unhappy, but most other mental health were more common among respondents who said their relationship was unclear or complicated. Single respondents also showed slightly higher proportions of most STIs.

Table 9.17 Key morbidities by relationship status group

Relationship status groups and morbidities	Single (n = 648)	Steady partner (n = 768)	Complicated (n = 93)	All (N = 1509)
% with severe anxiety and depression[a]	6.5	3.4	6.5	5.0
% with self-harm thoughts[a]	18.8	12.4	22.6	15.8
% sexually unhappy[b]	21.8	10.2	8.6	15.1
% with potential alcohol dependency[c]	19.3	18.9	25.8	19.5
% diagnosed with HIV, ever	7.6	11.7	8.6	9.8
% diagnosed with HIV, last 12m	0.0	0.3	0.0	0.1
% with detectable viral load[d]	2.1	0.0	n < 20	0.7
% with active hepatitis B or C	0.0	0.5	0.0	0.3
% diagnosed with mpox[e]	0.8	0.9	0.0	0.8
% diagnosed with syphilis[f]	7.3	4.8	12.9	6.4
% diagnosed with gonorrhoea[f]	14.8	12.8	9.7	13.5
% diagnosed with chlamydia[f]	12.2	12.6	14.0	12.5
% diagnosed with anal/genital warts[g]	16.8	18.3	19.6	17.7

[a] last two weeks; [b] scoring less than 5 on the 1 to 10 scale; [c] last two weeks (PHQ-4); [d] among HIV-diagnosed; [e] since 2022; [f] last 12 months; [g] ever

9.4.2 Partnership status and behaviour

With respect to behaviour, respondents in a steady relationship were slightly less likely to report sexual risk behaviour than the other two groups.

Table 9.18 Key behaviour by relationship status group

Relationship status groups and behaviours	Single (n = 648)	Steady partner (n = 768)	Complicated (n = 93)	All (N = 1509)
% engaging in safer sex[a]	56.3	51.3	46.2	53.1
% using condoms consistently[b]	23.6	24.0	16.7	23.3
% taking PrEP[c]	31.9	25.0	26.9	28.1
% taking ART[d]	93.9	87.6	n < 20	89.7
% who ever took HIV-PEP[c]	14.4	14.1	11.8	14.0
% using antibiotics for STI prophylaxis[e]	7.9	8.1	7.5	8.0
Number (median) of NON-STEADY male sex partners	8	5	5	6
Sexual Repertoire Score (mean)[f]	6.0	6.3	5.8	6.1
% engaging in chemsex[g]	5.4	5.2	11.8	5.7
% injecting drugs[h]	1.6	2.1	4.3	2.0

[a] consistent condom or PrEP use or undetectable viral load; [b] consistent condom use with NON-STEADY male intercourse partners; [c] excluding HIV-diagnosed; [d] among HIV-diagnosed; [e] took antibiotics in the last 12 months, '(e.g., doxycycline) before or after having sex to reduce the risk of getting some sexually transmitted infections. (Doxy PrEP/Doxy-PEP'; [f] The Sexual Repertoire Score (SRS) is an additive score ranging from 1 to 9, based on previous-12-months engagement in 9 sexual practices with NON-STEADY male partners.; [g] defined as using stimulant drugs to make sex more intense or last longer, last 4 weeks; [h] excluding steroids, last 12 months

9.4.3 Partnership status and needs

Unmet need was most common in the group of respondents who were single or those who were unsure if they were in a relationship or not. Drug use concerns were notably more common in the single respondents.

Table 9.19 Key needs by relationship status group

Relationship status groups and needs	Single (n = 648)	Steady partner (n = 768)	Complicated (n = 93)	All (N = 1509)
Score (mean) for the SIHS (0–6)[a]	1.3	0.8	1.4	1.1
% concerned about own drug use	6.6	3.4	2.2	4.7
% lacking control over safer sex	11.0	8.5	7.5	9.5
% lacking control over unwanted sex	9.6	6.9	11.8	8.3
% experiencing homo- or transnegative violence[b]	2.5	1.7	3.2	2.1
% experiencing physically forced or coerced to have sex[b]	2.2	1.2	2.2	1.7
% experienced stigma in healthcare facilities[b]	8.0	5.7	5.4	6.7
% anticipated stigma in healthcare facilities[b]	10.6	8.2	9.7	9.3
% feeling unsafe in public spaces[b]	25.0	21.5	17.2	22.7
Number (mean) of unknown HIV/STI transmission facts (0–6)	1.9	1.7	1.8	1.8
% not knowing U=U[c]	14.6	11.7	21.7	13.6
Number (mean) of unknown PrEP facts (0–6)	1.8	1.8	2.0	1.8
% unaware of PrEP	15.9	15.3	28.2	16.4
Number (mean) of unknown HIV test/treat facts (0–7)	1.6	1.6	1.8	1.6
% not knowing where to test for HIV	3.4	1.8	2.2	2.5
Number (mean) of unknown hepatitis facts (0–5)	1.7	1.7	1.6	1.7
% not knowing where to get hepatitis A/B vaccination	10.5	8.2	8.6	9.2
Number (mean) of unknown HPV facts (0–3)	2.1	2.1	1.9	2.1
% not knowing that HPV vaccine exists	36.1	32.8	30.0	34.0
Number (mean) of unknown mpox facts (0–3)	2.0	1.8	1.8	1.9
% not knowing that mpox vaccine exists	19.4	14.7	18.2	16.9
% not knowing where to get mpox vaccination	31.2	28.2	35.5	29.9

[a] Short Internalised Homonegativity Scale; [b] last 12 months; [c] a person with undetectable viral load cannot pass on HIV sexually

9.4.4 Partnership status and interventions

Data on access to sexual health interventions similarly show that single respondents and those reporting their relationship status as ‘complicated’ have less access to most interventions than respondents with a steady partner, although the pattern is not quite so clear cut as with needs. While HIV prevalence was highest in respondents in a steady relationship, single and ‘it’s complicated’ respondents with diagnosed HIV were less likely to have an undetectable viral load (HIV care cascade stage 6). Compared to respondents in a steady relationship, they were also less likely to have been offered any hepatitis vaccination or to have ever received a hepatitis A, B, or mpox vaccination.

Table 9.20 Key interventions by relationship status group

Relationship status groups and interventions	Single (n = 648)	Steady partner (n = 768)	Complicated (n = 93)	All (N = 1509)
% saw or heard MSM-specific information about HIV or STIs[a]	90.3	92.3	92.5	91.5
% offered hepatitis vaccination by health service[b]	72.2	76.0	66.7	73.8
% with full course of HAV vaccination[c]	64.4	73.9	63.2	69.1
% with full course of HBV vaccination[d]	70.2	74.5	62.1	71.9
% with at least one shot of HPV vaccine	20.7	20.8	17.2	20.5
% with at least one shot of mpox vaccine[e]	32.4	33.3	30.1	32.7
% who received free condoms[af]	31.9	38.0	37.6	35.4
% spoken to about PrEP at a health service[g]	51.3	47.9	49.4	49.5
% tested for HIV[ah]	66.0	57.6	76.3	62.4
% using community HIV-testing at last HIV test	42.0	41.1	50.0	42.1
% using self-sampling at last HIV test	1.0	1.6	0.0	1.2
% using self-testing at last HIV test	3.3	2.8	9.3	3.4
% linked to care (HIV care cascade stage 3)[i]	100.0	100.0	n < 20	100.0
% retained in care (HIV care cascade stage 4)[i]	100.0	100.0	100.0	100.0
% on ART (HIV care cascade stage 5)[i]	100.0	100.0	100.0	100.0
% virally suppressed (HIV care cascade stage 6)[i]	97.8	100.0	100.0	99.2
% tested for STIs[a]	67.6	63.3	68.8	65.5
% receiving anal swabbing[a]	53.4	49.3	44.1	50.8
% with substance use counselling / self-support group[a]	2.4	0.9	1.9	1.6

[a] last 12 months; [b] ever; [c] excluding respondents with past hepatitis A; [d] excluding respondents with past hepatitis B; [e] excluding respondents with past mpox; [f] from civil society organisations, clinic, bars, or saunas; [g] excluding HIV-diagnosed; [h] excluding respondents diagnosed prior to that; [i] among HIV-diagnosed

9.5 Migrancy inequalities

Section 3.5 examines whether respondents are migrants, their regions of origin, and their reasons for migration. Refugees and asylum seekers reported the lowest proportions with higher education, steady partners, or being out about their sexual attraction to men. All migrant groups showed higher proportions engaged in sex work—particularly refugees and asylum seekers (999 %)—and in injection drug use.

Table 9.21 Key demographics by migrancy status group

Migration background and demographics	Born in country of residence (n = 1080)	Refugees and asylum seekers (n = 7)	Migrated to live as gay or bisexual (n = 101)	Other migrants (n = 320)	All (N = 1508)
Age (mean)	45.3	37.9	43.7	42.8	44.6
Age (SD)	15.2	n < 20	10.5	12.2	14.4
Age (median)	45	38	43	43	44
% with higher education	59.8	n < 20	75.0	72.7	63.5
% with current steady partner	49.9	n < 20	77.2	46.6	50.9
% fully out[a]	54.4	n < 20	68.3	50.0	54.2
% sex workers[b]	1.4	n < 20	2.0	2.8	1.8
% PWID[c]	2.0	n < 20	3.0	1.9	2.0

[a] all/almost all know about sexual attraction to men; [b] sold sex 3+ times, last 12m; [c] People who inject drugs (excluding steroids), last 12m

9.5.1 Migrancy and morbidities

Refugees and asylum seekers were more likely to report poor mental health. They were also the most likely to have ever or recently been diagnosed with HIV and, overall, to have detectable HIV. Current hepatitis B or C was similarly prevalent (999 %) as among respondents with diagnosed HIV (0.7 %). In contrast, gonorrhoea, chlamydia, and anal or genital warts appeared to be more commonly experienced by respondents who migrated to live as gay or bisexual men.

Table 9.22 Key morbidities by migrancy status group

Migration background groups and morbidities	Born in country of residence (n = 1080)	Refugees and asylum seekers (n = 7)	Migrated to live as gay or bisexual (n = 101)	Other migrants (n = 320)	All (N = 1508)
% with severe anxiety and depression[a]	5.0	n < 20	4.0	4.7	5.0
% with self-harm thoughts[a]	15.6	n < 20	18.8	14.7	15.8
% sexually unhappy[b]	16.3	n < 20	11.9	12.5	15.1
% with potential alcohol dependency[c]	18.2	n < 20	18.8	23.9	19.5
% diagnosed with HIV, ever	9.4	n < 20	15.0	9.4	9.8
% diagnosed with HIV, last 12m	0.0	n < 20	0.0	0.7	0.1
% with detectable viral load[d]	1.0	-	n < 20	0.0	0.7
% with active hepatitis B or C	0.3	n < 20	0.0	0.3	0.3
% diagnosed with mpox[e]	0.6	n < 20	0.0	1.6	0.8
% diagnosed with syphilis[f]	6.2	n < 20	7.9	5.6	6.4
% diagnosed with gonorrhoea[f]	12.8	n < 20	12.9	15.9	13.5
% diagnosed with chlamydia[f]	11.0	n < 20	14.9	16.6	12.5
% diagnosed with anal/genital warts[g]	16.1	n < 20	22.8	21.6	17.7

[a] last two weeks; [b] scoring less than 5 on the 1 to 10 scale; [c] last two weeks (PHQ-4); [d] among HIV-diagnosed; [e] since 2022; [f] last 12 months; [g] ever

9.5.2 Migrancy and behaviour

Sexual risk with non-steady partners, including numbers of partners, sexual repertoires [1], injecting and chemsex were most common among respondents who had migrated to live sexually liberated lives. They were also above average users of taking PrEP. Refugees and asylum seekers were also more likely than average to be injecting drugs but were less likely to be using ART or PrEP. Using antibiotics for STI prophylaxis ('doxy-PEP') was substantially more common across all migrant groups.

Table 9.23 Key behaviour by migrancy status group

Migration background groups and behaviours	Born in country of residence (n = 1080)	Refugees and asylum seekers (n = 7)	Migrated to live as gay or bisexual (n = 101)	Other migrants (n = 320)	All (N = 1508)
% engaging in safer sex[a]	50.5	n < 20	60.4	59.1	53.1
% using condoms consistently[b]	23.1	n < 20	24.3	23.1	23.3
% taking PrEP[c]	26.2	n < 20	30.7	32.8	28.1
% taking ART[d]	86.1	-	n < 20	100.0	89.7
% who ever took HIV-PEP[c]	13.5	n < 20	10.9	16.9	14.1
% using antibiotics for STI prophylaxis[e]	5.9	n < 20	12.9	13.2	8.0
Number (median) of NON-STEADY male sex partners	5	11	7	10	6
Sexual Repertoire Score (mean)[f]	6.1	4.4	6.3	6.0	6.1
% engaging in chemsex[g]	4.9	n < 20	9.9	6.9	5.7
% injecting drugs[h]	2.0	n < 20	3.0	1.9	2.0

[a] consistent condom or PrEP use or undetectable viral load; [b] consistent condom use with NON-STEADY male intercourse partners; [c] excluding HIV-diagnosed; [d] among HIV-diagnosed; [e] took antibiotics in the last 12 months, '(e.g., doxycycline) before or after having sex to reduce the risk of getting some sexually transmitted infections. (Doxy PrEP/Doxy-PEP'; [f] The Sexual Repertoire Score (SRS) is an additive score ranging from 1 to 9, based on previous-12-months engagement in 9 sexual practices with NON-STEADY male partners.; [g] defined as using stimulant drugs to make sex more intense or last longer, last 4 weeks; [h] excluding steroids, last 12 months

Similarly, non-migrant MSM were substantially less likely to report all risk behaviour, including having had less non-steady partners in the last 12 months. Among the migrants, refugees and asylum seekers were most likely to report the most sexual risk behaviour but there is more variety in the behavioural measures and less consistency in the pattern for the three migrant groups.

9.5.3 Migrancy and needs

For most of indicators, refugees and asylum seekers were most likely to be in need, including those associated with specific precautionary behaviour (hepatitis vaccination; access to HIV testing; access to condoms etc.) and for educational/information-based needs. The proportion reporting drug use concerns was notably high, as was internalised homonegativity. As a group, refugees and asylum seekers experienced a high level of homophobic violence and rape, as well as stigma in health care facilities.

Table 9.24 Key needs by migrancy status group

Migration background groups and needs	Born in country of residence (n = 1080)	Refugees and asylum seekers (n = 7)	Migrated to live as gay or bisexual (n = 101)	Other migrants (n = 320)	All (N = 1508)
Score (mean) for the SIHS (0–6)[a]	1.0	1.6	0.9	1.1	1.1
% concerned about own drug use	3.9	n < 20	7.9	5.9	4.7
% lacking control over safer sex	9.4	n < 20	9.9	9.4	9.5
% lacking control over unwanted sex	8.1	n < 20	8.9	8.8	8.4
% experiencing homo- or transnegative violence[b]	2.1	n < 20	3.0	1.9	2.1
% experiencing physically forced or coerced to have sex[b]	1.7	n < 20	3.0	1.2	1.7
% experienced stigma in healthcare facilities[b]	6.0	n < 20	5.9	8.8	6.7
% anticipated stigma in healthcare facilities[b]	9.0	n < 20	6.9	11.2	9.4
% feeling unsafe in public spaces[b]	23.2	n < 20	18.8	21.2	22.7
Number (mean) of unknown HIV/STI transmission facts (0–6)	1.8	1.7	1.4	1.6	1.8
% not knowing U=U[c]	14.6	n < 20	16.0	8.8	13.6
Number (mean) of unknown PrEP facts (0–6)	1.8	2.0	1.6	1.8	1.8
% unaware of PrEP	17.5	n < 20	10.6	13.9	16.4
Number (mean) of unknown HIV test/treat facts (0–7)	1.6	3.5	1.5	1.6	1.6
% not knowing where to test for HIV	2.7	n < 20	1.0	1.9	2.5
Number (mean) of unknown hepatitis facts (0–5)	1.7	1.5	1.6	1.7	1.7
% not knowing where to get hepatitis A/B vaccination	8.3	n < 20	8.9	11.9	9.2
Number (mean) of unknown HPV facts (0–3)	2.1	2.6	2.1	1.9	2.1
% not knowing that HPV vaccine exists	37.4	n < 20	26.7	24.2	34.0
Number (mean) of unknown mpox facts (0–3)	1.9	2.0	1.8	2.1	1.9
% not knowing that mpox vaccine exists	17.6	n < 20	17.2	14.1	16.9
% not knowing where to get mpox vaccination	29.3	n < 20	27.0	33.1	30.0

[a] Short Internalised Homonegativity Scale; [b] last 12 months; [c] a person with undetectable viral load cannot pass on HIV sexually

9.5.4 Migrancy and interventions

As a group, refugees and asylum seekers were less likely than average to encounter information about HIV and STIs or access to vaccinations. Those with HIV were less likely to have their infection monitored and managed and were more likely to be detectable.

Table 9.25 Key interventions by migrancy status group

Migration background groups and interventions	Born in country of residence (n = 1080)	Refugees and asylum seekers (n = 7)	Migrated to live as gay or bisexual (n = 101)	Other migrants (n = 320)	All (N = 1508)
% saw or heard MSM-specific information about HIV or STIs[a]	91.4	n < 20	89.1	92.8	91.4
% offered hepatitis vaccination by health service[b]	73.9	n < 20	71.3	74.4	73.8
% with full course of HAV vaccination[c]	68.3	n < 20	76.3	70.0	69.1
% with full course of HBV vaccination[d]	70.2	n < 20	80.0	75.6	71.9
% with at least one shot of HPV vaccine	19.4	n < 20	21.8	23.8	20.6
% with at least one shot of mpox vaccine[e]	30.8	n < 20	43.0	36.0	32.7
% who received free condoms[af]	35.3	n < 20	40.6	33.4	35.4
% spoken to about PrEP at a health service[g]	48.0	n < 20	52.9	53.1	49.4
% tested for HIV[ah]	60.3	n < 20	62.4	69.1	62.3
% using community HIV-testing at last HIV test	41.8	n < 20	35.4	44.7	42.1
% using self-sampling at last HIV test	1.2	n < 20	0.0	1.7	1.2
% using self-testing at last HIV test	3.6	n < 20	0.0	4.0	3.4
% linked to care (HIV care cascade stage 3)[i]	100.0	-	n < 20	100.0	100.0
% retained in care (HIV care cascade stage 4)[i]	100.0	-	100.0	100.0	100.0
% on ART (HIV care cascade stage 5)[i]	100.0	-	100.0	100.0	100.0
% virally suppressed (HIV care cascade stage 6)[i]	98.9	-	100.0	100.0	99.2
% tested for STIs[a]	63.0	n < 20	70.3	72.5	65.5
% receiving anal swabbing[a]	49.8	n < 20	51.5	53.4	50.7
% with substance use counselling / self-support group[a]	1.6	n < 20	0.0	2.2	1.6

[a] last 12 months; [b] ever; [c] excluding respondents with past hepatitis A; [d] excluding respondents with past hepatitis B; [e] excluding respondents with past mpox; [f] from civil society organisations, clinic, bars, or saunas; [g] excluding HIV-diagnosed; [h] excluding respondents diagnosed prior to that; [i] among HIV-diagnosed

9.6 HIV diagnosis inequalities

The prevalence of respondents diagnosed with HIV in the sample is reported in **Section 4.3.1**. Below we provide the indicators separately for respondents with and without diagnosed HIV. Respondents with diagnosed HIV were older, more likely to be out about their sexual attraction to men and were more likely to report sex work or PWID.

Table 9.26 Key demographics by HIV status group

HIV status groups and demographics	Not HIV-diagnosed (n = 1351)	Diagnosed with HIV (n = 146)	All (N = 1497)
Age (mean)	43.6	53.5	44.6
Age (SD)	14.3	11.5	14.3
Age (median)	43	55	44
% with higher education	64.1	58.2	63.5
% with current steady partner	49.7	61.0	50.8
% fully out	52.8	65.8	54.0
% born abroad[a]	28.1	30.8	28.4
% sex workers[b]	1.9	1.4	1.8
% PWID[c]	1.0	11.6	2.0

[a] all/almost all know about sexual attraction to men; [b] sold sex 3+ times, last 12m; [c] People who inject drugs (excluding steroids), last 12m

9.6.1 HIV diagnosis and morbidities

Other infections were notably more common among respondents with diagnosed HIV than those without. In contrast, poor mental health, sexual unhappiness and alcohol dependency were slightly more common among those without diagnosed HIV.

Table 9.27 Key morbidities by HIV status group

HIV status groups and morbidities	Not HIV-diagnosed (n = 1351)	Diagnosed with HIV (n = 146)	All (N = 1497)
% with severe anxiety and depression[a]	4.9	4.2	4.9
% with self-harm thoughts[a]	16.0	13.0	15.7
% sexually unhappy[b]	15.3	14.4	15.2
% with potential alcohol dependency[c]	20.1	14.4	19.5

HIV status groups and morbidities	Not HIV-diagnosed (n = 1351)	Diagnosed with HIV (n = 146)	All (N = 1497)
% with active hepatitis B or C	0.2	0.7	0.3
% diagnosed with mpox[e]	0.6	2.7	0.8
% diagnosed with syphilis[f]	5.8	11.6	6.4
% diagnosed with gonorrhoea[f]	12.5	21.2	13.4
% diagnosed with chlamydia[f]	11.7	19.9	12.5
% diagnosed with anal/genital warts[g]	16.2	32.6	17.8

[a] last two weeks; [b] scoring less than 5 on the 1 to 10 scale; [c] last two weeks (PHQ-4); [e] since 2022; [f] last 12 months; [g] ever

HIV-diagnosed respondents reported way more diagnoses of syphilis, gonorrhoea, and chlamydia in the last 12 months, more mpox since 2022, and were more likely to ever have been diagnosed with anal or genital warts or have active hepatitis B or C. Although older than the comparison group, HIV-diagnosed respondents did not have poorer mental health, they also reported slightly less sexual unhappiness and were less likely to be alcohol dependent.

9.6.2 HIV diagnosis and behaviour

Since ART and PrEP are each relevant to only one of the two groups, and because the question on PEP use was not asked of people with diagnosed HIV, these data are not shown. Respondents with diagnosed HIV reported higher numbers of sexual partners and higher Sexual Repertoire Scores [1]. Combining stimulants with sex, as well as injection drug use, was notably more common among respondents with diagnosed HIV. Despite a low proportion reporting condom use with non-steady male partners, the overall indicator of safer sex remained very high, thanks to U=U.

Table 9.28 Key behaviour by HIV status group

HIV status groups and behaviours	Not HIV-diagnosed (n = 1351)	Diagnosed with HIV (n = 146)	All (N = 1497)
% engaging in safer sex[a]	48.6	98.6	53.4
% using condoms consistently[b]	25.7	4.9	23.3
% using antibiotics for STI prophylaxis[e]	6.8	18.5	8.0
Number (median) of NON-STEADY male sex partners	6	10	6
Sexual Repertoire Score (mean)[f]	6.0	6.8	6.1
% engaging in chemsex[g]	4.3	17.8	5.6
% injecting drugs[h]	1.0	11.6	2.0

[a] consistent condom or PrEP use or undetectable viral load; [b] consistent condom use with NON-STEADY male intercourse partners; [e] took antibiotics in the last 12 months, '(e.g., doxycycline) before or after having sex to reduce the risk of getting some sexually transmitted infections. (Doxy PrEP/Doxy-PEP'; [f] The Sexual Repertoire Score (SRS) is an additive score ranging from 1 to 9, based on previous-12-months engagement in 9 sexual practices with NON-STEADY male partners.; [g] defined as using stimulant drugs to make sex more intense or last longer, last 4 weeks; [h] excluding steroids, last 12 months

9.6.3 HIV diagnosis and needs

Respondents with diagnosed HIV were significantly more likely not to be as safe sexually as they wanted to be, to lack access to condoms and to be concerned about drug use. People with diagnosed HIV were better informed about vaccinations. Conversely, respondents without diagnosed HIV were significantly more likely to be ignorant about U=U.

Table 9.29 Key needs by HIV status group

HIV status groups and needs	Not HIV-diagnosed (n = 1351)	Diagnosed with HIV (n = 146)	All (N = 1497)
Score (mean) for the SIHS (0–6)[a]	1.1	0.8	1.1
% concerned about own drug use	4.0	10.3	4.6
% lacking control over safer sex	9.0	13.0	9.4
% lacking control over unwanted sex	8.9	4.1	8.4
% experiencing homo- or transnegative violence[b]	2.1	2.1	2.1
% experiencing physically forced or coerced to have sex[b]	1.9	0.0	1.7
% experienced stigma in healthcare facilities[b]	7.0	4.1	6.7
% anticipated stigma in healthcare facilities[b]	10.0	4.1	9.4
% feeling unsafe in public spaces[b]	24.1	11.0	22.8
Number (mean) of unknown HIV/STI transmission facts (0–6)	1.8	1.7	1.8
% not knowing U=U[c]	14.9	0.7	13.5
Number (mean) of unknown HIV test/treat facts (0–7)	1.6	1.2	1.6
Number (mean) of unknown hepatitis facts (0–5)	1.7	1.5	1.7
% not knowing where to get hepatitis A/B vaccination	9.7	4.8	9.2
Number (mean) of unknown HPV facts (0–3)	2.1	2.0	2.1
% not knowing that HPV vaccine exists	34.0	34.5	34.0
Number (mean) of unknown mpox facts (0–3)	1.9	1.8	1.9
% not knowing that mpox vaccine exists	17.7	11.0	17.0
% not knowing where to get mpox vaccination	31.9	12.4	30.0

[a] Short Internalised Homonegativity Scale; [b] last 12 months; [c] a person with undetectable viral load cannot pass on HIV sexually

9.6.4 HIV diagnosis and interventions

Respondents without diagnosed HIV were less likely to encounter or access any of the interventions surveyed. In contrast, those with diagnosed HIV were more likely to report receiving substance use counselling or attending self-support groups related to substance use.

Table 9.30 Key interventions by HIV status group

HIV status groups and interventions	Not HIV-diagnosed (n = 1351)	Diagnosed with HIV (n = 146)	All (N = 1497)
% saw or heard MSM-specific information about HIV or STIs[a]	91.3	93.2	91.4
% offered hepatitis vaccination by health service[b]	72.5	85.6	73.8
% with full course of HAV vaccination[c]	67.7	85.4	69.3
% with full course of HBV vaccination[d]	70.7	83.6	71.9
% with at least one shot of HPV vaccine	20.2	23.3	20.5
% with at least one shot of mpox vaccine[e]	30.2	54.5	32.6
% who received free condoms[af]	35.1	36.3	35.2
% using community HIV-testing at last HIV test	45.2	19.2	42.4
% using self-sampling at last HIV test	1.3	0.7	1.3
% using self-testing at last HIV test	3.8	0.7	3.5
% tested for STIs	62.8	89.7	65.4
% receiving anal swabbing	49.9	56.8	50.6
% with substance use counselling / self-support group	1.2	3.7	1.5

[a] last 12 months; [b] ever; [c] excluding respondents with past hepatitis A; [d] excluding respondents with past hepatitis B; [e] excluding respondents with past mpox; [f] from civil society organisations, clinic, bars, or saunas

9.7 Sex work inequalities

Section 3.9 describes the frequency of buying and selling sex in the sample. Below, we present the indicators separately for respondents who had sold sex three or more times in the past 12 months (1.8 %), those who had done so less frequently (2.4 %), those who sold sex further in the past, and those who had never sold sex.

Although we did not ask respondents whether they identified as sex workers, selling sex more than twice in the past year provides a useful proxy for sex work [2]. Across the groups defined by selling sex frequency, the proportions of migrants and people who inject drugs increased with frequency, while average age decreased. It is notable however that in this sample, the median age of sex workers was 36.

Table 9.31 Key demographics by groups – selling sex

Selling drug use groups and demographics	Sold sex more than twice, last 12m (n = 27)	Sold sex less frequently, last 12m (n = 36)	Sold sex longer ago (n = 203)	Never sold sex (n = 1243)	All (N = 1509)
Age (mean)	39.3	40.2	44.6	44.9	44.6
Age (SD)	12.9	14.8	13.0	14.5	14.3
Age (median)	36	40	44	45	44
% with higher education	55.6	58.3	58.1	64.7	63.5
% with current steady partner	40.7	27.8	56.7	50.8	50.9
% fully out[a]	63.0	55.6	66.5	52.0	54.2
% born abroad	44.4	30.6	29.1	27.9	28.4
% PWID[c]	0.0	0.0	4.9	1.6	2.0

[a] all/almost all know about sexual attraction to men; [c] People who inject drugs (excluding steroids), last 12m

9.8.1 Sex work and morbidities

Respondents who sold sex were more likely to experience all infection-related conditions, including recently diagnosed HIV, detectable HIV, and active hepatitis B or C. In contrast, they reported lower levels of sexual unhappiness.

Table 9.32 Key morbidities by groups – selling sex

Selling sex groups and morbidities	Sold sex more than twice, last 12m (n = 27)	Sold sex less frequently, last 12m (n = 36)	Sold sex longer ago (n = 203)	Never sold sex (n = 1243)	All (N = 1509)
% with severe anxiety and depression[a]	3.8	8.3	3.4	5.1	5.0
% with self-harm thoughts[a]	22.2	30.6	17.2	15.0	15.8
% sexually unhappy[b]	7.4	8.3	11.4	16.0	15.1
% with potential alcohol dependency[c]	25.9	36.1	24.1	18.1	19.5
% diagnosed with HIV, ever	7.4	13.9	17.8	8.4	9.8
% diagnosed with HIV, last 12m	0.0	0.0	0.0	0.2	0.1
% with detectable viral load[d]	n < 20	n < 20	0.0	1.0	0.7
% with active hepatitis B or C	7.4	0.0	0.5	0.1	0.3
% diagnosed with mpox[e]	0.0	0.0	3.4	0.4	0.8
% diagnosed with syphilis[f]	3.7	22.2	7.9	5.7	6.4
% diagnosed with gonorrhoea[f]	18.5	16.7	15.3	13.0	13.5
% diagnosed with chlamydia[f]	22.2	11.1	20.2	11.1	12.5
% diagnosed with anal/genital warts[g]	37.0	22.2	24.6	16.0	17.7

[a] last two weeks; [b] scoring less than 5 on the 1 to 10 scale; [c] last two weeks (PHQ-4); [d] among HIV-diagnosed; [e] since 2022; [f] last 12 months; [g] ever

9.7.2 Sex work and behaviour

Respondents who sold sex were more likely to engage in drug-related risk behaviours. PrEP use increased with the frequency or recency of selling sex—offsetting lower condom use—along with higher rates of chem-sex and injecting drug use. However, among respondents living with HIV, ART use was less common in those who sold sex. Across groups defined by the frequency of selling sex, the number of sexual partners increased, but the sexual repertoire remained more or less unchanged.

Table 9.33 Key behaviour by groups – selling sex

Selling sex groups and behaviours	Sold sex more than twice, last 12m (n = 27)	Sold sex less frequently, last 12m (n = 36)	Sold sex longer ago (n = 203)	Never sold sex (n = 1243)	All (N = 1509)
% engaging in safer sex[a]	59.3	66.7	62.1	51.2	53.1
% using condoms consistently[b]	12.0	9.1	20.0	24.9	23.3
% taking PrEP[c]	40.7	44.4	30.5	27.0	28.1
% taking ART[d]	n < 20	n < 20	91.7	88.3	89.7
% who ever took HIV-PEP[c]	14.8	13.9	17.7	13.4	14.0
% using antibiotics for STI prophylaxis[e]	14.8	8.6	13.3	6.9	8.0
Number (median) of NON-STEADY male sex partners	11	11	10	5	6
Sexual Repertoire Score (mean)[f]	6.1	6.2	6.5	6.0	6.1
% engaging in chemsex[g]	7.4	8.3	13.3	4.3	5.7
% injecting drugs[h]	0.0	0.0	4.9	1.6	2.0

[a] consistent condom or PrEP use or undetectable viral load; [b] consistent condom use with NON-STEADY male intercourse partners; [c] excluding HIV-diagnosed; [d] among HIV-diagnosed; [e] took antibiotics in the last 12 months, '(e.g., doxycycline) before or after having sex to reduce the risk of getting some sexually transmitted infections. (Doxy PrEP/Doxy-PEP'; [f] The Sexual Repertoire Score (SRS) is an additive score ranging from 1 to 9, based on previous-12-months engagement in 9 sexual practices with NON-STEADY male partners.; [g] defined as using stimulant drugs to make sex more intense or last longer, last 4 weeks; [h] excluding steroids, last 12 months

9.7.3 Sex work and needs

For most of indicators, respondents who frequently sold sex were most likely to be in need. Respondents who sold sex were more likely to experience homophobic violence and rape and were more commonly lacking control over unwanted sex.

Table 9.34 Key needs by groups – selling sex

Selling sex groups and needs	Sold sex more than twice, last 12m (n = 27)	Sold sex less frequently, last 12m (n = 36)	Sold sex longer ago (n = 203)	Never sold sex (n = 1243)	All (N = 1509)
Score (mean) for the SIHS (0–6)[a]	0.6	1.0	1.0	1.1	1.1
% concerned about own drug use	3.7	8.3	6.4	4.3	4.7
% lacking control over safer sex	7.4	16.7	11.8	8.9	9.5
% lacking control over unwanted sex	18.5	13.9	8.9	7.9	8.3
% experiencing homo- or transnegative violence[b]	11.1	0.0	2.0	2.0	2.1
% experiencing physically forced or coerced to have sex[b]	3.7	5.6	1.0	1.6	1.7
% experienced stigma in healthcare facilities[b]	22.2	8.3	4.9	6.6	6.7
% anticipated stigma in healthcare facilities[b]	11.1	11.1	7.4	9.6	9.3
% feeling unsafe in public spaces[b]	25.9	25.0	24.6	22.3	22.7
Number (mean) of unknown HIV/STI transmission facts (0–6)	1.3	1.4	1.9	1.8	1.8
% not knowing U=U[c]	14.8	16.7	13.8	13.4	13.6
Number (mean) of unknown PrEP facts (0–6)	1.3	2.1	2.0	1.8	1.8
% unaware of PrEP	8.0	16.1	16.3	16.6	16.4
Number (mean) of unknown HIV test/treat facts (0–7)	2.3	1.6	1.5	1.6	1.6
% not knowing where to test for HIV	3.7	0.0	1.5	2.7	2.5
Number (mean) of unknown hepatitis facts (0–5)	1.4	1.9	1.8	1.7	1.7
% not knowing where to get hepatitis A/B vaccination	11.1	5.6	9.4	9.3	9.2
Number (mean) of unknown HPV facts (0–3)	2.2	2.2	2.1	2.1	2.1
% not knowing that HPV vaccine exists	26.9	44.4	34.0	33.9	34.0
Number (mean) of unknown mpox facts (0–3)	2.3	2.0	2.1	1.9	1.9
% not knowing that mpox vaccine exists	37.0	29.4	16.0	16.3	16.9
% not knowing where to get mpox vaccination	33.3	16.7	28.1	30.6	29.9

[a] Short Internalised Homonegativity Scale; [b] last 12 months; [c] a person with undetectable viral load cannot pass on HIV sexually

9.7.4 Sex work and interventions

Respondents who sold sex were more likely to have been tested for STIs in the past 12 months, including anal swabbing, and to have received counselling about PrEP at a health service. Conversely, they were not more likely to have been offered hepatitis vaccination, and among those living with HIV, viral suppression was less common.

Table 9.35 Key interventions by groups – selling sex

Selling sex groups and interventions	Sold sex more than twice, last 12m (n = 27)	Sold sex less frequently, last 12m (n = 36)	Sold sex longer ago (n = 203)	Never sold sex (n = 1243)	All (N = 1509)
% saw or heard MSM-specific information about HIV or STIs[a]	92.6	88.9	95.6	90.8	91.5
% offered hepatitis vaccination by health service[b]	70.4	69.4	78.8	73.2	73.8
% with full course of HAV vaccination[c]	69.2	70.6	77.3	67.8	69.1
% with full course of HBV vaccination[d]	75.0	71.4	74.2	71.5	71.9
% with at least one shot of HPV vaccine	33.3	22.2	24.6	19.5	20.5
% with at least one shot of mpox vaccine[e]	25.9	41.7	38.9	31.6	32.7
% who received free condoms[af]	48.1	52.8	36.5	34.4	35.4
% spoken to about PrEP at a health service[g]	72.0	67.7	53.0	48.0	49.5
% tested for HIV[ah]	66.7	75.0	65.0	61.5	62.4
% using community HIV-testing at last HIV test	42.9	41.7	36.2	43.1	42.1
% using self-sampling at last HIV test	4.8	0.0	1.0	1.3	1.2
% using self-testing at last HIV test	9.5	5.6	4.1	3.1	3.4
% linked to care (HIV care cascade stage 3)[i]	n < 20	n < 20	100.0	100.0	100.0
% retained in care (HIV care cascade stage 4)[i]	100.0	100.0	100.0	100.0	100.0
% on ART (HIV care cascade stage 5)[i]	100.0	100.0	100.0	100.0	100.0
% virally suppressed (HIV care cascade stage 6)[i]	100.0	100.0	100.0	98.9	99.2
% tested for STIs[a]	77.8	80.6	76.4	63.0	65.5
% receiving anal swabbing[a]	66.7	58.3	57.1	49.2	50.8
% with subst. use counselling / self-support group[a]	0.0	3.8	2.0	1.5	1.6

[a] last 12 months; [b] ever; [c] excluding respondents with past hepatitis A; [d] excluding respondents with past hepatitis B; [e] excluding respondents with past mpox; [f] from civil society organisations, clinic, bars, or saunas; [g] excluding HIV-diagnosed; [h] excluding respondents diagnosed prior to that; [i] among HIV-diagnosed

9.8 Drug injecting inequalities

Section 5.6 reports on the prevalence of injecting in the sample. Below, we present indicators for respondents who injected to get high in the past 12 months (2 %) compared with those who did not. Injectors were substantially older and, partly due to their higher age, were more likely to report higher education. They were less likely to have a steady partner and more likely to have been born abroad or frequently selling sex.

Table 9.36 Key demographics by groups – injecting to get high

Injecting drug use groups and demographics	Injected drugs, last 12m (n = 30)	Did not inject drugs, last 12m (n = 1449)	All (N = 1479)
Age (mean)	49.9	44.4	44.5
Age (SD)	11.2	14.4	14.4
Age (median)	48	44	44
% with higher education	63.3	63.6	63.6
% with current steady partner	53.3	50.5	50.6
% fully out[a]	63.3	53.9	54.1
% born abroad	30.0	28.3	28.3
% sex workers[b]	0.0	1.9	1.8

[a] all/almost all know about sexual attraction to men; [b] sold sex 3+ times, last 12m

9.8.1 Drug injecting and morbidities

While respondents who injected were less likely to be sexually unhappy than those who did not, all other morbidities—including hepatitis B and C—were more common among injectors. This group also included many more respondents living with HIV, who were much more likely to have received their HIV diagnosis in the past 12 months.

Table 9.37 Key morbidities by groups – injecting to get high

Injecting drug use groups and morbidities	Injected drugs, last 12m (n = 30)	Did not inject drugs, last 12m (n = 1449)	All (N = 1479)
% with severe anxiety and depression[a]	6.7	4.9	5.0
% with self-harm thoughts[a]	10.0	15.7	15.6
% sexually unhappy[b]	16.7	15.2	15.2
% with potential alcohol dependency[c]	27.6	19.3	19.4
% diagnosed with HIV, ever	56.7	8.2	9.2
% diagnosed with HIV, last 12m	n < 20	0.2	0.1
% with detectable viral load[d]	n < 20	0.8	0.7
% with active hepatitis B or C	0.0	0.3	0.3
% diagnosed with mpox[e]	3.3	0.7	0.7
% diagnosed with syphilis[f]	23.3	6.0	6.4
% diagnosed with gonorrhoea[f]	40.0	12.7	13.3
% diagnosed with chlamydia[f]	30.0	11.9	12.3
% diagnosed with anal/genital warts[g]	40.0	16.9	17.3

[a] last two weeks; [b] scoring less than 5 on the 1 to 10 scale; [c] last two weeks (PHQ-4); [d] among HIV-diagnosed; [e] since 2022; [f] last 12 months; [g] ever

9.8.2 Drug injecting and behaviour

Respondents who injected drugs had substantially higher numbers of sexual partners, a higher sexual repertoire score [1] and were much more likely to engage in chemsex or use ‘doxy-PEP’. They were less likely to use condoms but more likely to take PrEP, thereby engaging in safer sex.

Table 9.38 Key behaviour by groups – injecting to get high

Injecting drug use groups and behaviours	Injected drugs, last 12m (n = 30)	Did not inject drugs, last 12m (n = 1449)	All (N = 1479)
% engaging in safer sex[a]	83.3	52.2	52.9
% using condoms consistently[b]	0.0	24.4	23.8
% taking PrEP[c]	30.0	28.0	28.1
% taking ART[d]	n < 20	89.0	89.7
% who ever took HIV-PEP[c]	10.0	14.0	13.9
% using antibiotics for STI prophylaxis[e]	33.3	7.3	7.8
Number (median) of NON-STEADY male sex partners	11	6	6
Sexual Repertoire Score (mean)[f]	7.3	6.1	6.1
% engaging in chemsex[g]	50.0	4.1	5.1

[a] consistent condom or PrEP use or undetectable viral load; [b] consistent condom use with NON-STEADY male intercourse partners; [c] excluding HIV-diagnosed; [d] among HIV-diagnosed; [e] took antibiotics in the last 12 months, '(e.g., doxycycline) before or after having sex to reduce the risk of getting some sexually transmitted infections. (Doxy PrEP/Doxy-PEP'; [f] The Sexual Repertoire Score (SRS) is an additive score ranging from 1 to 9, based on previous-12-months engagement in 9 sexual practices with NON-STEADY male partners.; [g] defined as using stimulant drugs to make sex more intense or last longer, last 4 weeks

9.8.3 Drug injecting and needs

Respondents who injected drugs were more likely to report needs related to control over their sexual activity and lack of access to condoms. They were also much more likely to express concern about their drug use. However, injectors were more knowledgeable about HIV (including U=U), STIs, PEP, PrEP and hepatitis, than non-injectors.

Table 9.39 Key needs by groups – injecting to get high

Injecting drug use groups and needs	Injected drugs, last 12m (n = 30)	Did not inject drugs, last 12m (n = 1449)	All (N = 1479)
Score (mean) for the SIHS (0–6)[a]	0.7	1.1	1.1
% concerned about own drug use	33.3	3.7	4.3
% lacking control over safer sex	16.7	9.2	9.4
% lacking control over unwanted sex	10.0	8.3	8.3
% experiencing homo- or transnegative violence[b]	0.0	2.2	2.2
% experiencing physically forced or coerced to have sex[b]	0.0	1.7	1.6
% experienced stigma in healthcare facilities[b]	0.0	6.8	6.7
% anticipated stigma in healthcare facilities[b]	3.3	9.5	9.4
% feeling unsafe in public spaces[b]	20.0	22.9	22.9
Number (mean) of unknown HIV/STI transmission facts (0–6)	1.0	1.8	1.8
% not knowing U=U[c]	3.3	13.7	13.5
Number (mean) of unknown PrEP facts (0–6)	1.5	1.8	1.8
% unaware of PrEP	n < 20	16.7	16.5
Number (mean) of unknown HIV test/treat facts (0–7)	1.3	1.6	1.6
% not knowing where to test for HIV	0.0	2.6	2.6
Number (mean) of unknown hepatitis facts (0–5)	1.4	1.7	1.7
% not knowing where to get hepatitis A/B vaccination	6.7	9.2	9.1
Number (mean) of unknown HPV facts (0–3)	1.9	2.1	2.1
% not knowing that HPV vaccine exists	40.0	33.9	34.0
Number (mean) of unknown mpox facts (0–3)	1.3	1.9	1.9
% not knowing that mpox vaccine exists	3.3	17.0	16.7
% not knowing where to get mpox vaccination	13.3	30.3	30.0

[a] Short Internalised Homonegativity Scale; [b] last 12 months; [c] a person with undetectable viral load cannot pass on HIV sexually

9.8.4 Drug injecting and interventions

Respondents who injected to get high in the past 12 months accessed most interventions to a similar or greater extent than those who did not inject. Injectors were more likely to have been offered and received hepatitis vaccination, to have received counselling about PrEP at a health service, and to have been tested for STIs in the past 12 months—including anal swabbing. They were also, unsurprisingly, more likely to report receiving substance use counselling or attending self-support groups related to substance use.

Table 9.40 Key interventions by groups – injecting to get high

Injecting drug use groups and interventions	Injected drugs, last 12m (n = 30)	Did not inject drugs, last 12m (n = 1449)	All (N = 1479)
% saw or heard MSM-specific information about HIV or STIs[a]	96.7	91.3	91.4
% offered hepatitis vaccination by health service[b]	90.0	73.6	74.0
% with full course of HAV vaccination[c]	89.7	68.7	69.1
% with full course of HBV vaccination[d]	88.9	71.8	72.1
% with at least one shot of HPV vaccine	13.3	20.8	20.7
% with at least one shot of mpox vaccine[e]	66.7	31.9	32.6
% who received free condoms[af]	30.0	35.4	35.3
% spoken to about PrEP at a health service[g]	n < 20	49.1	49.4
% tested for HIV[ah]	40.0	63.1	62.7
% using community HIV-testing at last HIV test	30.0	42.4	42.2
% using self-sampling at last HIV test	0.0	1.3	1.3
% using self-testing at last HIV test	6.7	3.4	3.4
% linked to care (HIV care cascade stage 3)[i]	n < 20	100.0	100.0
% retained in care (HIV care cascade stage 4)[i]	100.0	100.0	100.0
% on ART (HIV care cascade stage 5)[i]	100.0	100.0	100.0
% virally suppressed (HIV care cascade stage 6)[i]	100.0	99.0	99.2
% tested for STIs[a]	96.7	64.6	65.2
% receiving anal swabbing[a]	80.0	50.0	50.6
% with substance use counselling / self-support group[a]	13.3	0.9	1.3

[a] last 12 months; [b] ever; [c] excluding respondents with past hepatitis A; [d] excluding respondents with past hepatitis B; [e] excluding respondents with past mpox; [f] from civil society organisations, clinic, bars, or saunas; [g] excluding HIV-diagnosed; [h] excluding respondents diagnosed prior to that; [i] among HIV-diagnosed

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Chapter 10: Summary and Conclusions

10.1 Recruitment and Demographics

Switzerland, as a co-funding country, achieved one of the highest recruitment rates in EMIS-2024, with 5.2 participants per 10 000 men aged 15–65 and a final sample size of N = 1509 [1].

Recruitment efforts by the **Swiss AIDS Federation** and their satellites contributed substantially, accounting for up to 45 % of respondents in Switzerland; this included 28 % via Grindr and Grindr for Equality, and 27 % via ROMEO.

The Swiss EMIS-2024 sample is broadly representative of the national population. The median age of participants in Switzerland was 44 years, closely matching the official census figure (43 years, BFS/OFS). Across Europe, median ages ranged from 24 years in Eastern Europe to 44 years in Switzerland, France, and the Netherlands.

About 28 % of participants were born abroad, primarily in Germany, France, and Italy, closely matching national statistics (27 %, BFS/OFS). The distribution of languages spoken by participants also reflects the Swiss population: 61.5 % reported German (BFS/OFS: 62 %), 21.9 % French (BFS/OFS: 23 %), 4.2 % Italian (BFS/OFS: 8 %), 8.9 % English, and 3.5 % other languages, spanning 30 remaining languages (Spanish and Portuguese 1 % each).

Regarding disclosure of sexual orientation, 72 % of Swiss participants reported being “out,” placing Switzerland in the upper quartile among European countries. Comparable levels were observed in Austria, Germany, France, the Czech Republic, and Sweden, whereas rates ranged from below 20 % in Albania and Kosovo to over 80 % in Norway, Spain, and Israel. In Switzerland, levels of “outness” are generally high, though there is considerable variation across regions.

Self-reported data appear reliable; for example, employment by age aligns with national expectations, supporting the internal validity of the data.

10.2 Morbidities

Swiss respondents reported the lowest proportion of severe depression or anxiety among participating countries, at 5 % (European range: 5–24 %). Alcohol-related issues were at a mid-range level, lower than in Austria, Germany, and France, but higher than in Italy. A CAGE-4 scores indicating problematic alcohol use were particularly high in Zürich.

Around 10 % of the Swiss sample reported a diagnosed HIV infection, placing Switzerland in a lower-to-medium position within Europe, while newly diagnosed HIV cases were among the lowest observed, at 0.1 % (based on 2 respondents).

Bacterial STIs such as syphilis and symptomatic gonorrhoea were at the upper range, affecting 6 % and 5 % of respondents respectively, with all bacterial STIs combined reaching 22 %. Zürich was identified as an mpox hotspot within Switzerland, consistent with epidemiological surveillance. Mpox prevalence was low compared with other Western European countries, and self-reported mpox vaccination rates closely matched real-world vaccine uptake in Switzerland, the EEA, and the UK, supporting the external validity of the data.

Self-reported STI and viral hepatitis data appear highly reliable; prevalence estimates are consistent with 2016–17 measures from the Swiss STAR trial [2], reinforcing confidence in both internal associations and external validity.

10.3 Risk and Precaution Behaviour

Switzerland was among the countries with the highest PrEP coverage (32 %), although rates in France and the United Kingdom were substantially higher.

Consistent condom use was relatively low, showing the expected inverse relationship between PrEP use and condom use: countries with higher PrEP uptake generally reported lower condom use, and vice versa.

Around one in ten participants in Switzerland reported behaviours associated with an elevated risk of HIV transmission. Use of antibiotics for STI prevention, mostly doxycycline post-exposure prophylaxis (doxy-PEP), was relatively high (8 %), with approximately half of users taking antibiotics without medical supervision.

While PrEP and condom use varied markedly across regions, differences in HIV risk were relatively small. Most MSM in Switzerland reported having sex while sober. Doxy-PEP use was particularly common among participants living with diagnosed HIV and among PrEP users, with higher rates in French- and Italian-speaking regions. Frequent unsupervised antibiotic use among PrEP users underscores the need for medical guidance and prevention counselling.

Chemsex prevalence was above the European average (6 %) but lower than in Belgium, the Netherlands, and Spain. Reported drug use patterns followed the common G/M+/T profile: GHB/GBL, synthetic stimulants other than Mephedrone and Crystal Methamphetamine were the top three drugs used for chemsex in Switzerland, though there was evidence of a gradual shift towards new synthetic stimulants. The *"Rösti-Graben"*—the cultural and linguistic divide between German- and French-speaking regions—was also reflected in substance use patterns during chemsex.

The Swiss sample displayed a broad sexual repertoire, and sex with non-steady partners involved considerable age mixing.

10.4 Needs

Knowledge of safer sex strategies was among the highest in Europe: 96 % of respondents were aware of condom use as HIV prevention, 84 % were familiar with PrEP, and 86 % understood the concept of U = U (Undetectable = Untransmittable).

Awareness of the mpox vaccine was similarly high (81 %), placing Switzerland among the top countries in Europe. Such knowledge was universal across regions. In contrast, awareness of the HPV vaccine was relatively low (66 %), positioning Switzerland in the lower range of European countries, despite cantonal reimbursement up to the age of 27. HPV vaccine awareness was notably lower in the German-speaking regions.

Levels of internalised homonegativity (SIHS) were among the lowest in Europe, indicating comparatively strong community resilience. Reports of physical violence within the previous 12 months were rare (< 5 %), placing Switzerland among the safest countries, with rates substantially below those observed in Russia (16 %) or Albania (25 %). Experiences of rape were also rare (< 2 %), though rates in the *Région Lémanique* were higher (3.5 %) and similar to those observed in neighbouring France.

Reports of homo- or trans-negative discrimination in healthcare settings were uncommon (< 2 %), while in several other countries, such as Israel and Kazakhstan, rates reached up to 13 %.

10.5 Interventions

Switzerland recorded the highest proportion of MSM-specific information exposure in Europe. Between 86 % and 95 % of respondents had seen MSM- or trans-specific HIV/STI information—reflecting a strong achievement by the Swiss AIDS Federation and their satellites.

Hepatitis A and B vaccination uptake was also among the highest, consistent with previous EMIS waves. It was high across all regions, though substantially lower in Ticino, likely due to small sample numbers. While mpox and HPV vaccination rates lagged behind hepatitis A/B, they remained relatively high, with over 50 % HPV vaccination coverage among eligible age groups. HPV vaccination coverage overall was around 20 %, above the European average but below the levels reported in Denmark, Italy, and the United Kingdom (32–34 %), Ireland (40 %), and Israel (43 %).

Mpox vaccination uptake ranked fourth in Europe (33 %), alongside Israel, following France (43 %), Denmark (38 %), and the United Kingdom (34 %).

Among Western European countries, Switzerland had the second-highest proportion of respondents tested for HIV in community-based voluntary counselling and testing (CBVCT) centres (42 %), after the Netherlands (53 %). High levels of CBVCT testing broadly reflect the established Checkpoint infrastructure in Switzerland.

Respondents consistently reported greater satisfaction with information and support during their last HIV test when tested in CBVCT settings. HCV testing was nearly as frequent as HIV testing among Swiss PrEP users. EMIS-2024 data also document a massive expansion of immediate or early ART initiation over time, particularly after 2015.

Anal swabbing was reported by over 50 % of participants in the past 12 months (*i.e.*, 2023/2024), placing Switzerland among the top seven European countries. Anal swabbing rates were very high among PrEP users and negatively influenced by the degree of sexual orientation concealment.

10.6 Trans Community

Transgender and non-binary people generally face worse mental health outcomes compared to cisgender people [3–5]. They experience higher rates of psychological distress, and they are more likely to receive a mental health diagnosis, such as depression or anxiety. Additionally, they are at a greater risk for suicidal ideation compared to the general population. All these known findings—despite small sub-sample sizes in Switzerland—could be replicated in EMIS-2024.

10.7 Health Inequalities

MSM who identify as gay or bisexual (gbMSM) are strongly affected by infections, more than all other sexual or gender identity groups. Other MSM, trans, and non-binary individuals experience predominantly mental health challenges, including sexual unhappiness.

In contrast, MSM with diagnosed HIV are strongly affected by infections, but less than other MSM by mental health issues or sexual unhappiness. However, among those diagnosed with HIV, levels of chemsex and drug injection are particularly high.

MSM sex workers and trans sex workers face high rates of sexually transmitted infections and viral hepatitis. While sexual unhappiness is relatively low in this group, mental health challenges are more prevalent. Less than half report consistent precautionary behaviours, highlighting unmet needs within this population.

Surveyed migrants to Switzerland exhibit smaller-than-expected inequalities in needs.

Overall, MSM sex workers and trans sex workers, along with MSM and trans women with diagnosed HIV, represent key groups with the highest levels of health and social support requirements.

Although cross-sectional and not representative, EMIS-2024 self-reported data displays a high level of internal and external validity and provides the most comprehensive and up-to-date insights into sexual health, HIV prevention, and service needs among sexual minority key populations in Switzerland, guiding evidence-based policy and targeted interventions.

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