

WARNING VOICES IN A POLICY VACUUM: PROFESSIONAL ACCOUNTS OF GAY MEN'S HEALTH IN AOTEAROA NEW ZEALAND

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Abstract

Internationally, public health policy and practice are increasingly recognising and focusing on gay men's health issues beyond HIV/AIDS. Against this background we consider how gay men's health is understood and considered in Aotearoa New Zealand, including identification of problems, aetiology and possible solutions. Semi-structured interviews with key informants involved in diverse professional roles in areas related to health for gay men were undertaken and three overarching themes identified. First, informants identified gay men's health as a legitimate area of concern within health policy. Second, they framed gay men's health in biopsychosocial terms, but highlighted socio-political factors. Third, the informants suggested that broad health-promoting strategies, coupled with targeted strategies, are needed to improve gay men's health. However, informants confirmed that there is very little mainstream policy interest in gay men's health; similarly, they identified little interest in broader health issues within the gay community. These findings contrast with many international settings where health for gay men is an emerging area of policy concern and health promotion activity, in both mainstream and gay-specific settings. We argue that the invisibility of gay men within health policy contributes to disempowering gay men, which is likely to contribute to continued health disparities for gay men. To conclude, the policy implications of these findings are discussed.

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INTRODUCTION

Population approaches to promoting health and wellbeing have for some time recognised interrelated social determinants of health that influence the health of populations, including gender, the social characteristics of people's neighbourhood, and social inclusion/exclusion, such as that arising from racism (Pickett and Pearl 2001, Wilkinson and Marmot 2003, World Health Organization 2004). While health policy and research routinely evaluate the influence of factors such as age, sex, gender and ethnicity (Loue 1999), historically there has been much less concern within policy settings with issues of sexual identity and behaviour.

However, in recent times social approaches to health are increasingly taking account of sexual identity and behaviour (Ministerial Advisory Committee on Gay and Lesbian Health 2003).² One result of this is that internationally public health policy and practice are now recognising and focusing on gay men's health issues beyond HIV/AIDS and acknowledging other serious health issues for gay men (Guthrie 2004, Meyer 2001, Rofes 1998, Swan 2004). This recent shift is typically framed and justified with reference to a research literature that identifies areas of health disparities between gay men and the male population in general. Two areas of research illustrate the disparity in health. Firstly, the use of crystal methamphetamine, particularly in the United States, has been closely linked to sexual risk-taking and identified as an emerging health problem among some groups of gay men.³ Secondly, the Christchurch Health and Development Study determined that non-heterosexual populations are an at-risk population for mental health problems (Fergusson et al. 2005, Fergusson et al. 1999). Predominantly homosexual males had an overall rate of mental health problems over five times the rate for exclusively heterosexual males, including suicide attempts (28.6% and 1.6% respectively) and suicide ideation (71.4% and 10.9%) (Fergusson et al. 2005).

These are, however, not the only areas where disparities between gay men and the general male population have been identified. For example, international research has identified disparities with respect to eating disorders (Russell and Keel 2002, Williamson 1999, Williamson and Spence 2001) and cigarette smoking (Gruskin and Gordon 2006, Ryan et al. 2001, Stall et al. 1999), while New Zealand research has identified disparities with respect to sexually transmitted infections (Saxton et al. 2002). These differentials support attention being paid to gay men's health and wellbeing issues and needs.

2 This Committee was established to provide expert advice to the government in Victoria, Australia.

3 See, for example, the 2006 Special Issue of the *Journal of Gay and Lesbian Psychotherapy*, Volume 10, No. 3/4.

Gay men's health is an important policy and research field to demarcate. Internationally, this is provided by some policy development and health promotion activity, and a growing body of research about specific health issues faced by gay men. In New Zealand, while there has been a limited amount of research, health promotion activity and policy development with health issues of particular concern to gay men such as HIV/AIDS (Ministry of Health 2003), alcohol (Alcohol Advisory Council of New Zealand and Ministry of Health 2001), and, more recently, suicide prevention (Associate Minister of Health 2006), there has been no specific policy concern with the broader aspects of gay men's health (Adams et al. 2004). Nor have gay men been included as a general population category of concern in most health policy development.

Arguments for including the health needs of gay men within public health policy in New Zealand can be situated within a *social rights* discourse, in which everyone is entitled to health, and where there are societal obligations to provide some level of health care (Bole 1991, Gruskin and Tarantola 2002). This discourse is evident in New Zealand health policy through two key principles relating to the universality of health and on extra attention for the disadvantaged, as expressed in the *New Zealand Health Strategy*: "Good health and wellbeing for all New Zealanders throughout their lives"; and "An improvement in health status of those currently disadvantaged" (Minister of Health 2000). The continued lack of policy concern appears to reflect a negative positioning of gay populations, which remains a point of difference from other defined sub-populations such as Māori (Minister of Health and Associate Minister of Health 2006), Pacific peoples (Ministry of Health 2002b), younger (Ministry of Health 2002c) and older people (Ministry of Health 2002a), all of which are targeted within New Zealand health policy under the umbrella of "disadvantage".

Given the policy vacuum around gay men's health issues, it seems a reasonable assumption that an "authoritative" view of the state of gay men's health in New Zealand, and key issues to consider, will come from those professionally involved in health service provision to gay men. In this paper we examine how such professionals see the issues around gay men's health. How are the problems identified? What causal attributions are offered? What are the possible solutions? How can useful health promotion initiatives be developed? We conclude by considering the interview data and the findings within the context of public health policy environments in New Zealand and internationally, discussing why gay men's health is not currently a significant policy issue, and suggesting ways that gay men's health could be incorporated within mainstream health policy.

METHOD

A qualitative semi-structured interview method was used. Interviews were conducted with 11 participants, including people working in policy/management and health promotion positions in government and non-government settings, physicians in private practice, and other clinicians working in public health settings (see Table 1 for details of these positions). The number and diversity of participants were appropriate to the small exploratory study we were engaged in, where the aim was to gather a rich insight into the understandings of the field among professionals working in the area.

Informants were chosen using purposive sampling techniques on the basis of their involvement in gay men's health issues and to encapsulate diverse experiences in the area. Most of the informants were individuals known to the research team or people occupying specific roles in key organisations. Others were identified through recommendations made by people who had been interviewed. Nine of the informants were gay men. The data therefore comprise a mix of non-gay professionals reflecting on gay health issues from their professional perspective, and gay professionals providing personal and professional reflection on their community and gay health issues. Recruitment of informants continued until a diverse range of perspectives and expertise had been covered and interviews were no longer eliciting any substantive new insights. The data obtained and reported on in this paper reflect the views of *these* informants; they do not represent *all* possible views about gay men's health.

Table 1 Key Informant Details

	Role/descriptor	Organisation/sector
1	Public health manager	Ministry of Health
2	Public health service manager	Non-government sector
3	Queer youth health promoter	Non-government sector
4	Health promotion manager	Non-government sector
5	Project manager	Non-government sector
6	Public health professional / policy analyst	Ministry of Health
7	Nurse	District Health Board
8	Psychotherapist / alcohol and drug clinician	District Health Board
9	Doctor (in management position)	District Health Board
10	General practitioner (#1)	Private practice
11	General practitioner (#2)	Private practice

Interview questions sought to elicit informants' views on issues in gay men's health, including factors positively and negatively influencing health, relevant policies and health promotion activities, and research needs. All interviews were conducted in person by the first author. Interviews lasted between 45 and 95 minutes, depending on how much the participant had to say on the topic, and, with informants' consent, were audiotaped and transcribed. All data were anonymised, with participants choosing a professional identification for use in publications.

The data were thematically coded to identify repeated issues in participants' discussions of gay men's health. Thematic analysis is a useful analytic approach to look across an entire data set to find repeated patterns of meaning (Braun and Clarke 2006). It provides "thick descriptions" of the common elements of a number of accounts and displays the richness and diversity of participants' experiences, while respecting the integrity of particular stories (Denzin and Lincoln 1994, Patton 1990). Thematic analysis allows us to treat participants' stories as unproblematic tellings of experience, and it is particularly useful for providing a contextualising overview of the findings of research (Braun and Clarke 2006). Multiple readings of the interview data were undertaken by the first author to identify common themes. These initial codings were then reviewed and discussed with the other authors, and further refinement of the coding and analysis undertaken. Quotes presented in this paper have been edited slightly to facilitate ease of reading.

RESULTS

Our analysis resulted in the identification of three key overarching issues/themes:

- the identification of gay men's health as an area of policy concern
- the identification of social aspects of health as crucial
- the need for strategies to improve health for gay men as a group.

We describe and explore each of these in turn.

Gay Men's Health as an Area of Policy Concern

Gay men's health was seen as a legitimate area of concern for specific health policy, practice and research by most informants. Typically, participants justified this position with reference to particular areas of health where gay men were seen to do poorly compared with the male general population. For instance:

"HIV is the most obvious thing that comes to mind but they do [gay men] have a high rate of STI ... other health issues I think are drugs and alcohol use, probably emotional issues really." (Nurse)

This informant identified several health issues that have been raised in the New Zealand research literature as areas of concern for gay men's health. The identification of HIV and sexually transmitted infections (STI) is consistent with Saxton et al. (2002), who reported that men who have sex with men are disproportionately affected by sexually transmitted infections as well as HIV; while the informant's identification of emotional issues is congruent with the mental health research already mentioned (Fergusson et al. 2005, Fergusson et al. 1999). In contrast, the references to drug and alcohol use are not substantiated by any significant New Zealand research, suggesting that the informant is drawing on other sources of information, such as professional practice and personal knowledge and experiences, to identify these as areas of health concern. The extract is also in line with the wider issue of the absence of a substantive local research base of gay health issues to draw on. Along with this, some informants noted that they rarely consulted overseas research, making the issue of a local research base all the more pertinent if gay health issues are to be identified accurately and addressed appropriately and successfully.

Despite informants drawing on significant professional, personal and, in some instances, community knowledge, many expressed reservations about their authority to discuss areas of disparity in gay men's health. For example, in one account scientific knowledge was privileged when the (gay) informant observed that he did not have the research available to say whether there was a problem with gay men and alcohol and drug use. Interestingly, earlier in the interview he had drawn on his personal, community and professional knowledge to note that at least for some gay men (those with sexual identity issues), "alcohol and drug addiction is pretty common" (Doctor).

While the dominant pattern identified was that health for gay men is poorer than for men in the general male population, a few informants saw gay men's health as, in some ways, better than that of other men:

"In many respects [gay men] are probably much healthier than their straight counterparts when you look at them physically ... but then under the surface it might be different, emotionally they might be not so healthy." (Nurse)

This account illustrates that for some informants, gay men's health was not necessarily an issue of either unequivocally better or worse and points to complexities in how gay men's health status is conceptualised. This extract is also interesting because it identifies different modes of health. The informant opens up the definition of health to broad conceptualisations that go beyond conventional concerns with the biopsychosocial.

The interviews with informants typically focused on health issues that reflect deficits in individual gay men. These included problems such as alcohol and drug use: "There

are issues that are more prevalent in the male gay community and I think those will often be around alcohol and drug abuse" (General practitioner #1). In doing so, the informants reproduced the popular individualised model of health (Dubos 1959, Seedhouse 1986), in which good or poor health results from the practices of the individual. Such an understanding allows policy and service provision to respond in decontextualised ways by addressing one particular health issue without necessarily acknowledging wider and related health concerns. While these may be beneficial for addressing particular issues, they risk ignoring systemic and environmental determinants of such health problems (Beaglehole 2002). For instance, in relation to gay men and alcohol use, we have argued elsewhere for the importance of looking beyond individual factors relating to alcohol use, and to incorporate and acknowledge the role of economic, political and social factors, both locally and globally (Adams et al. in press).

Key informants were asked about public policy or health interest around gay men's health issues as a whole in New Zealand, but they were not able to identify any significant policy work. They did, however, identify some policy and health promotion interest about specific health problems:

"I think – there is consciousness of gay men's health issues in a variety of settings ... probably the niche areas of health which are where these issues crop up and it may be the mental health arena and certainly in terms of alcohol and drug use and of course in the STI, HIV/AIDS arena." (Project manager)

This extract seems to reflect the state of gay health policy interest in New Zealand. We have previously identified that policy around gay men's health in New Zealand has not addressed broader policy issues and that policy development in specific areas is very limited (Adams et al. 2004). Further, according to the Ministry of Social Development (2006), their work in the area of gay health policy initially centred on specific areas, such as contributing to a review of the New Zealand Suicide Prevention Strategy.

In summary, informants identified that there are particular areas of concern for gay men's health apart from HIV, and these include STI, alcohol and drug use. The informants' views reflect the scientific research literature, while at the same time addressing the complexities of the patterns of gay men's health. Informants stressed that their ability to be authoritative on the subject was compromised to some degree by the lack of local empirical evidence available to them. Although gay men's health was established by the informants as a legitimate area of focused health interest, policy activity in only a few specific health areas was identified.

A Social Analysis of Health

Although key informants typically identified single, individualised health issues when talking about gay men's health, the overall quality of health for gay men was framed as a biopsychosocial issue (Engel 1977). In this section, we briefly discuss social (and psychological) factors. The impact of social factors was usually seen as negative, and as leading to poor personal health outcomes for some men. The following extracts identify social influences in different forms – oppression, homophobia and prejudice.

"It sounds pretty heavy doesn't it, oppression, but it is a person's status or a population group's status within the wider community that I think has a huge effect on their health status. (Interviewer: Right and so you would see gay men as an oppressed group?) Yes I think so, yep." (Public health manager)

"It is much more difficult in a homophobic environment for you to be healthfully gay because there is a whole lot of factors that are opposed to achieving that degree of acceptance in health." (Doctor)

"Just because a young person is gay, that doesn't make them have the problem, it is society's response and the prejudice which poses the barriers." (Queer youth health promoter)

In these three extracts the informants provided a social analysis of health – and highlighted the negative effects of various social determinants. This type of analysis contrasts with much of the analysis found in international policy documents, which tends to privilege biomedical aspects of health to some degree – either employing a disease-orientation approach solely and/or a risk-factor approach, which to some extent locates deficit in gay men (Adams et al. 2004).

As well as implicating society in general in contributing to poor gay men's health, some informants identified particular features of the gay community as a negative influence.

"From my experience the fact is sadly the – I've just read the *Express* [gay newspaper], for example – the peer pressure to be a happy homosexual, one should be in an alcohol and drug or drinking environment so we bring this on ourselves." (Psychotherapist)

"There used to be lots of groups ... we had all sorts of groups, many more than there seem to be now, and they were activist groups and that sort of self-help." (Doctor)

In the first extract the informant points to the potentially health-demoting activities of the gay scene. The commercial gay scene is a contested aspect of gay community life that is reviled by some but important to others. Gay bars, for instance, are important social spaces providing safe spaces for gay men to socialise, but they do not cater for all

gay men (Bennett and Coyle in press, Moore 1998) and are potentially risk-inducing in respect of alcohol and other drug use (Adams et al. in press).

Another systemic factor identified by informants, which may potentially compromise the health of gay men, was related to the doctor–patient clinical relationship. Informants felt that if you were not able to disclose your sexuality to the doctor then the clinical examination and treatment were potentially compromised. As one informant noted, you need to be sure the doctor has been “swabbing the right places” (Nurse). Doctors are increasingly encouraged to gain appropriate knowledge and skills and to adopt appropriate clinical practices so that gay men receive appropriate care (see, for example, Fox 2002, Gee 2006). However, as health care providers in New Zealand typically assume that their gay clients are heterosexual (Neville and Henrickson 2006), part of the responsibility for ensuring an appropriate clinical experience is borne by gay men themselves. While personal disclosure of sexuality or same-sex sexual behaviour to doctors is likely to be difficult for some men, Neville and Henrickson (2006) found that for those who have disclosed their sexuality to the provider, 82% found that the provider was completely comfortable with this disclosure, with 43% reporting that this disclosure influenced their care in a positive way.

Despite being questioned about factors that promote the health of gay men, informants had less to say on this matter. When it was discussed, health promotion covered both individual and social factors. Informants identified health-promoting individual factors, particularly those arising from countering the negative aspects of being gay: “We are quite fortunate in that for a lot of us we have had to deal with the pretty fundamental issue about who and what we are and we wind up stronger” (Doctor). This informant drew on the concept of resiliency (see, for example, Richardson 2002) and raised the possibility that gay men can potentially gain strength from having to counter the negative attitudes of wider society.

Informants also identified that the gay community potentially offers protective factors (as well as negative ones), including personal support from friendship groups or “gay family”. One informant argued that this provides emotional and social support, and a forum to discuss issues and obtain in-depth information. Another factor identified as contributing to gay men's health was the personal knowledge of health issues gained through activities like discussing health issues with other gay men and through reading men's health magazines.

In summary, informants typically framed the quality of gay men's individual health in biopsychosocial terms, including the effects of discrimination, the positive and negative influences of the gay community, and individual factors. In drawing on social and individual factors, informants signal the need to focus on both these aspects of health to improve gay men's health.

Improving the Health of Gay Men

Just as informants identified social and community factors influencing the health of gay men, strategies for improving health were also discussed at these levels:

“You could argue that yes of course people do need some level of information and knowledge ... but that is almost incidental to the process. The process is really about empowering men who have sex with men, specifically gay men, and creating supportive political, social, economic, health service environments around that group.” (Public health service manager)

In this extract the informant noted that while individual factors and the empowering of individual men have a role in improving health, what is more important is the effect of the environment within which a gay man finds himself. The Homosexual Law Reform Act 1986 and the subsequent legal protections afforded gay men (Human Rights Act 1993) were noted as significant in changing the social environment and in allowing for greater and more visible participation in society by gay men, which was associated with increased wellbeing. One informant outlined changes he had seen:

“People said that law reform wouldn’t make any difference. I remember that happening, homosexual reform and then the anti-discrimination legislation happened a few years after. People said it isn’t going to make any difference to anything, but it has.” (Nurse)

Socio-political analyses like these ensure the focus is on the adverse effects of social and structural processes, rather than focusing on individual deficits (Keogh and Weatherburn 2000). Health for gay men then is not something that can be entirely explained by individual-level factors and this is consistent with social approaches to understanding health.

Informants also advocated particular strategies to improve health. A key area of discussion centred on whether health services should be mainstream or gay-focused. Most informants argued that having both possibilities is likely to result in a better uptake of services. The possibility of a “one-stop-shop” health centre for gay men was mentioned by several informants – a centre that could offer coordinated client care, appropriate staff and be a focal point for health promotion. However, informants also identified disadvantages with this type of approach. One chief concern was that any gay-specific service might present an opportunity for mainstream health to abdicate responsibility for providing gay-appropriate services, and simply refer clients to the specialised gay service. Informants also proposed that use of such a service was not guaranteed as it was unlikely that all gay men would be comfortable using such a facility. A further problem noted was that with a small population base, the economic feasibility of such a service is doubtful. Other issues raised included the importance of

the clinical encounter for health, along with the need to ensure that services are at least "gay-friendly" and that practitioner's are "culturally" and professionally competent.

In summary, informants suggested that broad health-promoting strategies to counter the effects of oppression and discrimination are needed, coupled with targeted strategies such as gay-focused services or gay health clinics.

DISCUSSION AND POLICY ISSUES

In this section we conclude by drawing on aspects of the interview data to consider why gay men's health has not been such a significant policy issue. We also extend the discussion to ways that gay men's health could be incorporated within mainstream health policy.

Reasons for the failure of mainstream health policy to specifically address gay men's health issues were not explicitly or widely discussed in the interviews. However, one informant noted that the gay community is "no longer illegal although we still remain immoral" (Doctor). This statement provides an illustration that the position of gay men in New Zealand has changed enormously over the last 20 or so years. Although gay men are able to live more openly, many aspects of gay lives remain contested and under threat (Stevens 2004), as the protest and controversy surrounding the 2004 law change to allow same-sex civil unions demonstrated (Smith 2004).

The effects of heteronormativity – the societal privileging of heterosexuality (Johnson 2002) – is one factor that may contribute to the lack of policy (and research) interest in gay men's health issues. This relative invisibility of gay men's issues in health policy works to support the universalising of men's health experiences regardless of sexuality, and contributes to disempowering gay men by not acknowledging their specific health needs and treating all men's health needs together. This works, in a circular fashion, to replicate heteronormativity, by reproducing the invisibility of gay men (and indeed lesbian women) as a particular population of health concern. On a practical level, a programme of workshops developed by the Ministry of Social Development (2006) on gay (as well as lesbian, bisexual, transgender and intersex) issues for public sector policy advisors will help to challenge such heteronormativity in this sector.

A reluctance to "promote" gay health issues, identified in some informants' accounts, appears to reflect or anticipate a general antipathy to the provision of health care to gay men who are seen to have "brought it on themselves". Awareness that homosexuality is still considered unhealthy in all aspects (McCreanor 1996) and recognition that other gay-positive initiatives in New Zealand – such as civil unions (Smith 2004) – are subject to critical public scrutiny, does not provide a socio-political climate in which

advocating for gay health issues is easy. The interviews also revealed that despite most of the informants being gay men, there was little evidence that personal insights and views arising from their sexuality had been used to raise gay-specific issues, or to challenge or support the prevailing professional voices in the policy contexts within which they operate.

Along with the widespread indifference in mainstream health policy settings to gay health issues, informants also identified limited interest and involvement in health issues (apart from HIV/AIDS) by the gay male community. There are few opportunities readily available for gay men to partake in public debate around health issues (apart from HIV/AIDS). This means that on those limited occasions when gay health is discussed in mainstream settings, professional views are likely to dominate as gay community perspectives are unavailable to challenge and disrupt the professional account. As research from the field of men's health warns, professional health priorities are likely to be different from men's needs (Fletcher et al. 2002). Professional framing also makes it easier to adopt the position that being gay is a risk factor and to incorporate it into public health thinking (Hurley 2003). The potential consequences of such an approach are that public health fails to recognise complexity and diversity, including health-promoting factors, within gay men's lives (Adams et al. 2004).

Exclusion of gay-specific input also works against the principles of contemporary public health models, which acknowledge the importance of enabling people to increase control over their own health (World Health Organization 1986) and look to enhance social capital within communities (Putnam 2000). The academic literature and gay activists point to a number of ways gay men can potentially contribute to the framing of policy and practice around gay men's health and claim a political and social space (Keogh 2001), including:

- advocating for an approach to health that is not pathologising but is strengths-based and actively promotes wellbeing (Antonovsky 1996)
- focusing on improving social and physical environments, rather than on the typically individualistic personal-change strategies (Albee and Fryer 2003)
- ensuring health does not become "state-centred" and controlled, and thereby removed from the influence and control of gay men themselves (Epstein 2003)
- developing a coalition of gay men and allies in health promotion, such as funders, service providers and researchers (Hart 1997).

The combination of such factors may enhance the possibility of a gay-focused framework for health. The experience and involvement of gay community responses to HIV (Lindberg and McMorland 1996, Parkinson and Hughes 1987, Worth 2003), along with the current involvement of a least one government agency (Ministry of Social Development) in issues relating to gay health and wellbeing, could provide mechanisms for significant gay community engagement in health promotion and

health policy. Successful engagement with the gay community is, however, likely to be influenced by the small size of the population of gay men in New Zealand, coupled with the changing nature of the gay community, including changes resulting from law reform and those brought about by AIDS no longer being the crisis it once was (Grierson and Smith 2005).

Underpinning these discussions about gay men's health is the need for better research to inform both gay community involvement and activism, and mainstream health initiatives, nationally and internationally (Adams et al. 2004). Many of our informants identified the need for *local* research evidence to inform their work and strengthen the argument for including gay men's health issues in mainstream policy and service development. A lack of good-quality data contributes to potential neglect of important health issues for gay men (Meyer 2001), and in New Zealand there has been recent demand for better-quality information about gay men (and other non-heterosexual populations) (Hughes and Saxton 2006, Ministry of Social Development 2006).

The development of effective health promotion for any group, including gay men, is dependent upon a detailed understanding of their culture and social practices, which is only possible through the collection of robust data (Adams et al. 2004). Tailored, population-level health promotion strategies and environmental interventions aimed at improving the health and wellbeing of gay men in New Zealand, and beyond, require more sophisticated understanding of their health and masculinity. However, research on gay issues occupies a contested political space (Scarce 1999), and although investigations within gay communities can be challenging, innovative research efforts in New Zealand (e.g. the Lavender Islands: Portrait of the Whole Family study, which is the first national strengths-based survey of gay, lesbian and bisexual people in New Zealand, <http://lavenderislands.massey.ac.nz>) have been undertaken in recent times. The new research agenda does not assume pathology and deficits within individual gay men and opens up the possibility of studying the "everyday" experiences of gay men (Coyle and Wilkinson 2002) with a view to grounding policy and health promotion in lived realities.

In this paper, key informants identified that within New Zealand there is currently little mainstream interest in gay men's health, despite there being increasing international research evidence suggesting there are many areas of specific health concern. The continued invisibility of gay men's issues in New Zealand (and in many other countries) works to support the generalising of men's health experiences, regardless of sexuality, and contributes to disempowering gay men by not acknowledging their specific health needs or highlighting any aspects of health advantage. Without the acknowledgement of gay men's health issues within mainstream public health policy, and without the development of gay-specific health strategies based on robust research, gay men are likely to continue to experience disparities in health relative to straight men.

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