Enhancing Social Health Programming

for GBMSM with Meth Use Experience

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We acknowledge the land on which this research study took place. For thousands of years, this land has been the traditional territory of the Huron-Wendat, the Seneca, and the Mississaugas of the Credit. Today, this place remains home to many Indigenous peoples from across Turtle Island, and we are grateful for the opportunity to conduct this work on this land. We also acknowledge that Tkaronto, now known as Toronto, is covered by Treaty 13 with the Mississaugas of the Credit.

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Overview

This report presents key findings and recommendations based on a two-year qualitative study involving gay, bisexual, and other men who have sex with men (GBMSM) who have crystal methamphetamine (meth) use experience. We explore barriers and enablers of engagement in social health programming and propose actionable strategies for fostering inclusion, safety, and retention. Our goal is to inform and support providers and stakeholders working with this population.

Key Messages

1. Stigma continues to limit access and engagement, even in supportive settings.
Despite HQ's affirming environment, GBMSM who have meth use experience still report feeling judged or unsafe discussing their experiences. Reducing stigma must be an active, visible, and ongoing practice embedded in all levels of service delivery.

2. Programs must reflect the lived realities of those they aim to serve.
Social health programming that centers the cultural and experiential knowledge of GBMSM - especially through peer facilitation - creates trust, fosters safety, and increases retention.

3. Flexibility is not a bonus; it is a requirement.
People navigating meth use and complex life challenges need services that allow for re-entry, non-linear participation, and individualized pacing. Rigid models risk exclusion.

4. Sexual health and trauma are central, not peripheral, to social health.
Honest, structured conversations about sex, intimacy, and trauma are critical to making programs emotionally relevant and impactful. Avoiding these topics weakens program effectiveness.

5. Meeting basic needs enables deeper engagement.
When sleep, food, and hydration are overlooked, participation suffers. Addressing these foundational needs within programming signals dignity, care, and a genuine commitment to inclusion.

Background

Gay, bisexual, and other men who have sex with men (GBMSM) continue to face significant health disparities in Ontario, particularly when navigating the complex intersections of substance use, trauma, HIV risk, and social isolation. A report from the Ontario HIV Treatment Network states that "6.4% of the 865 Ontario-resident men interviewed [at 2014 World Pride] had used meth in the past six months," while other studies estimate that 6–10% of GBMSM in Ontario report recent meth use (OHTN, 2020). Among the estimated 218,000 GBMSM living in Ontario, 73,000 of whom reside in Toronto, those with lived/living experience of meth use encounter heightened barriers to connection, safety, and inclusion in supportive services (Ontario HIV Epidemiology and Surveillance Initiative, 2021).

Social health, defined as a balance between emotional wellbeing, social connection, and community belonging, is deeply impacted by structural stigma, systemic exclusion, and service fragmentation. Yet, programs that address the social health of GBMSM who have meth use experience remain limited and underdeveloped across the province.

HQ Toronto (HQ) operates as a sex-positive, stigma-free hub offering integrated sexual, mental, and social health services for cisgender men, two spirit, transgender, and non-binary individuals. This report shares what we learned between July 2023 and June 2025, while conducting three focus groups (n=28) and two member-checking sessions among clients of HQ, to assess the social health programming experience and needs of GBMSM who have meth use experience.

Of the 28 individuals participating (see Table 1 for participant demographics), year of birth ranged from 1957 to 2001. Participant racial and ethnic identities were diverse, including White/Caucasian (57%), Black (11%), Indigenous (11%), Latin American (10%), South Asian (7%), and Southeast Asian (4%).

"... programs that address the social health of GBMSM who have meth use experience remain limited and underdeveloped across the province"

While the majority were born in Canada (71%), several participants in each group were born elsewhere, including India, Vietnam, Colombia, Jamaica, Mexico, and Bulgaria. Most participants identified as men (89%), with a small number identifying as transgender (7%) or non-binary (4%). Living arrangements varied widely, encompassing private rentals (50%), supportive housing (29%), and staying with friends or family (14%). All participants had used meth, and all but one reported use within the past three months. Overall, 12 participants (43%) were living with HIV, nearly three times the proportion of people accessing HQ services who are HIV positive (15%).

The COVID-19 pandemic intensified challenges experienced by GBMSM who use meth. Lockdowns, service disruptions, and the closure of affirming spaces exacerbated experiences of loneliness, mental health distress, and disconnection from community. For many, this has contributed to increased risk of HIV transmission, suicidal ideation, and reduced access to affirming support (Ferlatte et al., 2019; Marziali et al., 2020; Slemon et al., 2021).

This report responds to these intersecting crises. Drawing on a qualitative research study conducted in collaboration with HQ, we explore how GBMSM who have meth use experience are included, and too often excluded, from social health programming. By surfacing beliefs and practices that either support or inhibit inclusion and retention, this report aims to guide service providers and stakeholders in building more equitable, relevant, and relationship-centered programming.

Key Findings

1.

Stigma (external and internal) remains a primary barrier

Participants consistently reported hesitation to engage, even within an affirming and sex-positive space like HQ, due to fear of judgment of meth use and related sexual behaviors. Stigma is not only external but also internalized, leading individuals to self-censor or disengage. Despite supportive messaging, participants sensed subtle cues that discouraged open dialogue about their lived experiences.

"Even inside (name of organization) … I feel like I can't discuss sex because I'm looked at a certain way. People don't say it out loud, but you can feel it - the pause, the shift in tone, the way they move on quickly. It's like they support you until it gets too real."

This underscores the importance of ensuring that anti-stigma efforts are not only embedded in policy but are also visible and enacted in every layer of care delivery, from intake to clinical conversations to group dynamics.

2.

Culturally competent care shapes safety, not just access

Participants emphasized that care delivered by those with shared cultural and experiential backgrounds fosters more than access, it creates emotional safety and deepens therapeutic outcomes. Peers were described as playing a vital role in shaping service culture, challenging clinician assumptions, and offering validation that cannot be replicated through professional training alone.

"As peers, we're also training clinicians. We create safety for conversations they might avoid."

This points to the necessity of valuing peer expertise as a form of cultural competency, one that is critical to dismantling stigma, creating trust, and inviting honest dialogue about drug use, sex, trauma, and identity.

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As peers, we're also training clinicians. We create safety for conversations they might avoid

3.

Flexibility is foundational to accessibility and retention

Rigid service structures can unintentionally exclude people who are navigating complex and changing life circumstances. Participants highlighted that meaningful engagement often happens non-linearly and over time. Programs that allow for re-entry after absence or relapse, repeat participation, and low-barrier access are more likely to support sustained involvement.

"You don't just get one shot. Some people need to do a group two or three times and that's okay."

This reflects a harm reduction-informed model of engagement that embraces the realities of meth use and recognizes recovery as an ongoing, adaptive process.

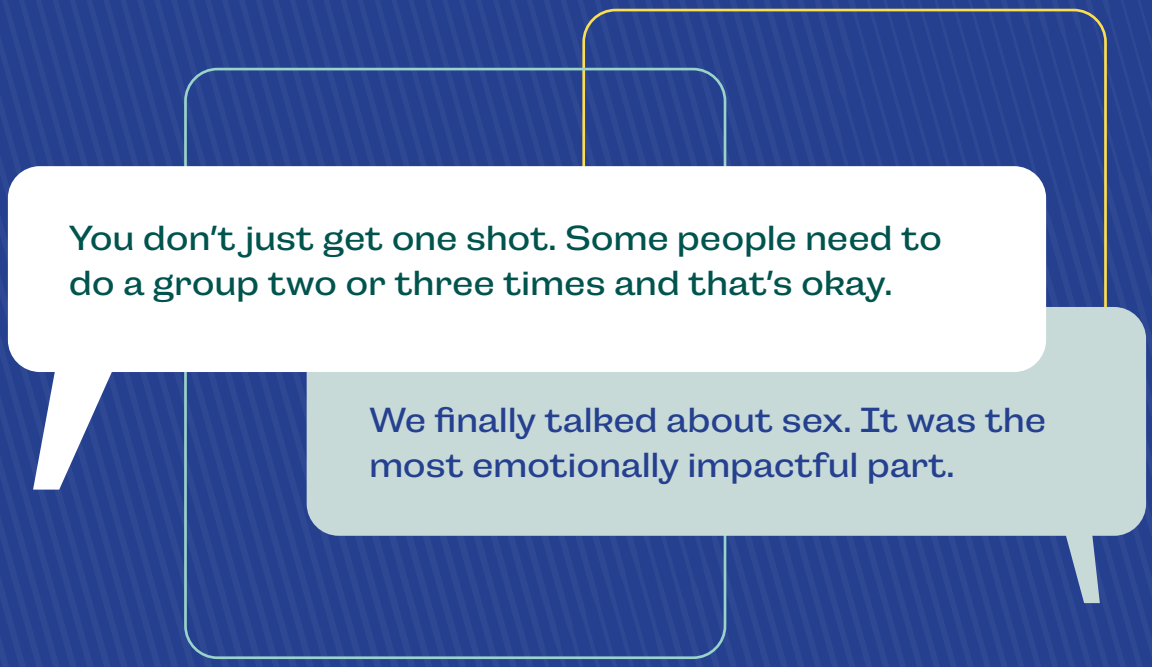
4.

Sexual health and trauma need intentional integration

Participants described feeling disconnected when programs avoided or de-emphasized sexual health and trauma, especially when these experiences were central to their drug use and personal histories. When space was made to talk about sex openly and non-judgmentally, it was described as cathartic and transformative.

"We finally talked about sex. It was the most emotionally impactful part."

Integrating structured discussions around sex, intimacy, consent, and trauma into group programming is not ancillary, it is essential to emotional resonance and healing.



5.

Basic needs must be structurally addressed

Sustainable engagement in social or therapeutic programs requires that participants' physiological needs are met. Many described struggling with sleep, nutrition, and hydration due to unstable housing, drug-related impacts, or mental health challenges. Addressing these needs is not optional - it is fundamental.

"Those are the three things (sleep, nutrition, and hydration) you need to stay alive. But when you're using, even getting one of those is a struggle. I can't think about healing or being in a group if I haven't eaten or slept."

Programs that incorporate snacks, hydration options, and quiet rest spaces are more likely to create environments where participants can show up consistently and meaningfully engage.

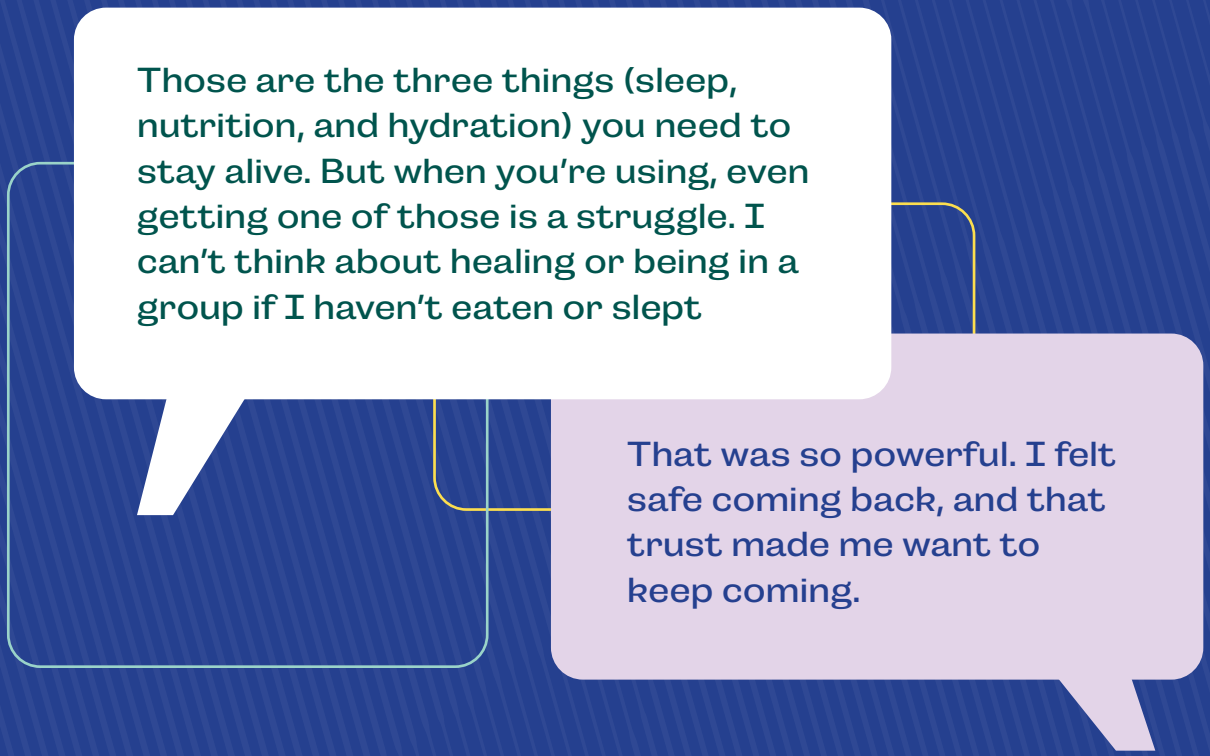
6.

Non-linear recovery and relationship-based retention are powerful

Participants stressed the importance of being welcomed back without judgment after periods of absence or return to use. Rather than emphasizing program completion, they valued sustained relational connection with facilitators and peers. Feeling recognized, accepted, and invited back was framed as a reason to continue engaging.

"That was so powerful. I felt safe coming back, and that trust made me want to keep coming."

This highlights the importance of designing retention strategies rooted in affirmation and care, rather than compliance or attendance metrics.



Strategic Recommendations for Social Health Programming

Expand Peer Leadership & Facilitation Roles

- Hire and compensate peers with meth use/ chemsex experience as co-designers and facilitators.
- Engage peer leaders in training clinicians, supporting drop-in groups, and co-creating program evaluation metrics.

Develop Cyclical, Open-Entry Groups

- Design social health groups allowing flexible attendance and re-entry.
- Include validation practices like welcome-back rituals or group reorientation sessions.

Integrate Sexual Health & Trauma Modules

- Embed structured discussions on sex, intimacy, and trauma within social groups.
- Partner with HQ's mental health and sexual health services to deliver this content collaboratively.

Meet Foundational Needs On-Site

- Offer snacks, beverages, and safe spaces for rest during group sessions.
- Explore partnerships with food security organizations and expand non-clinical support (e.g., legal and immigration clinics).

Strengthen Anti-Stigma Culture through Peer Practice

- Introduce regular reflective debriefs for all staff to surface bias and reinforce peer-led insights.
- Share peer narratives internally to educate team members and reinforce culture change.

Measure Success with Meaningful Metrics

- Redefine retention beyond attendance: measure participant-defined "connection," trust, and sense of belonging.
- Collect qualitative feedback; include questions like "Can you describe how, during your experience today, you did or did not feel seen, understood, or welcomed?"

Operational Considerations

Monitoring & Evaluation: Implement brief post-session surveys and ongoing member-checking mechanisms to ensure that peer leadership, flexibility, and sexual health integration are consistently experienced by participants.

Training Investment: Budget for ongoing peer facilitator development and trauma-informed care workshops.

Cross-Service Linkages: Formalize referral pathways with sexual and mental health teams to ensure timely, holistic professional support.

Community-Based Delivery: Pilot offsite or pop-up groups at the location/sites of trusted partners to reach clients unlikely to enter the main clinic space.

Next Steps

1. Stakeholder Workshop: Host a co-design session with peers, staff, and collaborators to operationalize the above recommendations.

2. Pilot Cycle: Launch one pilot peer-led, open-entry social health group cycle with integrated sexual-health modules.

3. Collect Data: Use short session feedback surveys to assess belonging, trust, and cultural relevance.

4. Scale & Share: If successful, broaden the model across other social programming, and document findings in a short internal case-study.

Conclusion

This report highlights the urgent need to center the voices and lived experiences of GBMSM who have meth use experience in the design, delivery, and evaluation of social health programming. Across focus groups and member-checking sessions, participants made clear that meaningful inclusion depends on more than access; it depends on trust, safety, affirmation, and responsiveness to complex and often non-linear experiences.

The findings highlight that stigma, both internal and external, remains a major barrier, even in spaces designed to be inclusive. Participants emphasized that culturally and experientially competent care, delivered by individuals who understand their realities, is essential to engagement. They also called for flexible, trauma-informed programs that integrate sexual health and address basic needs as part of the recovery process.

By taking these insights seriously, service providers and decision-makers can build programming that does not just include GBMSM with meth use experience but truly reflects and respects who they are. This work requires ongoing collaboration, structural change, and a commitment to equity at every level.

Moving forward, the recommendations offered here provide a road map for strengthening inclusion and retention in social health programming. By implementing them, we take a necessary step toward ensuring that all GBMSM, especially those living on the margins, can access the care, connection, and community they deserve.

"The findings highlight that stigma, both internal and external, remains a major barrier, even in spaces designed to be inclusive. "

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Table 1: Participant Demographics

Focus Group	1	2	3
Year of Birth	1957–2001 (Median: 1980)	1965–2000 (Median: 1986)	1957–1984 (Median: 1968)
Race/Ethnicity	Aboriginal: 1, Black: 1, Black and Aboriginal: 1, South Asian: 1, Southeast Asian: 1, White/Caucasian: 4	Black: 1, Latin American: 2, White/Caucasian and Aboriginal: 2 White/Caucasian: 4,	Black: 1, Latin American: 1, South Asian: 1, Southeast Asian: 1, White/Caucasian: 6
Born In	Canada: 6, Elsewhere: Bulgaria 1, India 1, Vietnam 1	Canada: 7, Elsewhere: Columbia 1, Mexico 1	Canada: 6, Elsewhere: Colombia 1, India 1, Jamaica 1, Vietnam 1
Gender Identity	Man: 7, Transgender: 2	Man: 8, Non-binary: 1	Man: 9, Non-binary: 1
Used Meth (Past 3 Months)	Yes: 9, No: 0	Yes: 9, No: 0	Yes: 9, No: 1
General Health	Poor: 1, Fair: 3, Good: 3, Very good: 1, Excellent: 1	Fair: 2, Good: 6, Very good: 1	Fair: 1, Good: 7, Very good: 1, Excellent: 1
Mental Health	Poor: 1, Fair: 4, Good: 2, Very good: 2	Fair: 4, Good: 3, Very good: 2	Fair: 3, Good: 6, Excellent: 1
Living with HIV	Yes: 3, No: 6	Yes: 4, No: 5	Yes: 5, No: 5