Mapping the current knowledge in syndemic research applied to Men who have Sex with Men: a Scoping Review

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# Abstract

Men who have sex with Men (MSM) represent a population affected by numerous health conditions. Syndemic theory has been used as a framework to study the health of MSM for nearly 20 years. However, the literature is plagued by a lack of consensus regarding what constitutes a synergy in a syndemic and recent reviews have shown that most of the papers published thus far have failed to demonstrate a synergy nor describe the bio-social interaction needed to account for a true syndemic. Moreover, to our knowledge, none of the existing reviews have focused specifically on MSM.

This scoping review aims to fill this gap by mapping in detail how syndemic research on MSM has been conducted. A systematic database search was conducted between 2020 and 2021 and 115 studies were included. Our findings showed a lack of diversity regarding the location, design, subpopulation and outcomes studied. In addition, the syndemic conditions as well as their measurement were not focused enough to ensure the robustness and reproducibility of the findings. Furthermore, our results support previous reviews showing a lack of empirical data to support disease interaction in syndemic research applied to MSM. Our review offers some important recommendations to help move the field forward in future work and describes some promising methodological advances.

# Introduction

## Background

Men who have sex with men (MSM) represent a population disproportionately affected by numerous health conditions. They represent 70% of new HIV diagnoses ([Center for Disease Control and Prevention, 2020](#X4cf13d81533c7b267d16e8ce422f52a6b94e857)) in the United States of America (USA) and more than half of new HIV diagnoses in the European Union/European Economic area ([European Centre for Disease Prevention and Control and WHO Regional Office for Europe, 2019](#Xe9d1574ea3592c13d78cb3440bd26eb0dba677a)). They are also more prone to contract other sexually transmitted diseases and *Nesseria Gonorrhea* strains from MSM exhibit higher antimicrobial resistance ([Centers for Disease Control and Prevention, 2019](#Xac65d4e2802ef6640efb692e7711ad3535446e3)). Furthermore, mental health conditions such as depression, anxiety, suicide attempts or self-harm are more prevalent among MSM ([Liu et al., 2019](#ref-Liu2019); [Luo et al., 2017](#ref-luo2017); [Ross et al., 2018](#ref-ross2018)) and substance use is more common than for their heterosexual counterparts([Medley et al., 2016](#ref-Medley2016)). Moreover, those adverse health outcomes are enmeshed within structural disadvantages such as violence, stigma, discrimination ([Collier et al., 2013](#ref-collier2013); [Lea et al., 2014](#ref-Lea2014); [Lee et al., 2016](#ref-Lee2016)) as well as with poverty, unemployment, unstable housing and poor access to healthcare ([Ayhan et al., 2020](#ref-ayhan2020); [Closson et al., 2018](#ref-closson2018)).

For more than 20 years, syndemic theory has provided a framework to examine the interrelations between social conditions, mental health and physical health ([Singer et al., 2017](#ref-singer2017)). Described for the first time in 1996 by Merrill Singer ([Singer, 1996](#ref-singer1996)), a syndemic consists of two or more interacting epidemics producing an excess burden in a population due to harmful social conditions ([Singer and Clair, 2003](#ref-singer2003))To speak of a syndemic, three conditions must be met ([Mendenhall and Singer, 2020](#ref-mendenhall2020)) :

1. Two or more conditions cluster in a given population
2. This clustering is due to an adverse social context such as poverty or stigmatization
3. There is some form of biological, social and/or behavioral interaction between the conditions, significantly worsening the health of the affected population

A syndemic is thus a holistic framework describing interactions both between diseases themselves and between diseases and the social environment contributing to their emergence, clustering and spread ([Singer et al., 2017](#ref-singer2017)). As such, its value for studying the health of marginalized populations such as MSM is undeniable.

## Rationale

Nevertheless, this framework is frequently misused by researchers. A systematic review conducted in 2015 showed the inadequacy of most of the literature in supporting one of its core tenets ([Tsai and Burns, 2015](#ref-tsai2015)). Indeed, that paper demonstrated that, although synergistic interaction between diseases lies at the core of the theory, most papers failed to use relevant statistics to demonstrate the existence of a synergy. More recently, a scoping review published in 2020 confirmed this finding that most recentlypublished citations did not describe the interactions between diseases needed to account for a true syndemic ([Singer et al., 2020](#ref-Singer2020)). Scholars in the field have been calling for greater clarity in the use of the concept and have urged researchers to describe more precisely the interactions they observe between health conditions ([Singer et al., 2021](#ref-singer2021) ; [Mendenhall and Singer, 2020](#ref-mendenhall2020)).

However, to our knowledge none of the existing reviews or recommendations have focused on syndemic literature applied specifically to MSM. We thus sought to fill this gap by conducting a scoping review with the objective to map the following:

1. the study design used,
2. the subpopulations of MSM studied,
3. the psychosocial conditions considered as forming a syndemic and how they were measured,
4. the outcomes studied,
5. the statistics used to evaluate the concept of interaction,
6. the hypothesis for biological and sociobiological interactions proposed by the authors, when available,
7. relevant frameworks that may compliment syndemic theory to better understand the health of MSM and,
8. the key findings of these studies.

With these data, we wanted to better understand the state of the art in the current literature, identify knowledge gaps and suggest recommendations to guide future research in the field.

# Methodology

The complete protocol of this scoping review was published in 2020 [Anonymous 2020].

We applied the framework suggested by Arskey and O’Malley ([Arksey and O’Malley, 2005](#ref-arksey2005)), with enhancements from Levac et al. ([Levac et al., 2010](#ref-levac2010)). We also considered the recommendations formulated by Colquhoun et al. ([Colquhoun et al., 2014](#ref-colquhoun2014)) and the updated guidance by Peters and colleagues ([Peters et al., 2020](#ref-peters2020)). We followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) ([Tricco et al., 2018](#ref-Tricco2018)). The completed checklist can be found in of the supplementary materials.

Screening and data charting was completed using DistillerSR (Evidence Partners, Ottawa, Canada). Scripts, statistics, charts, tables and the present paper was generated using R ([R Core Team, 2020](#ref-rcoreteam2020)), RStudio ([RStudio Team, 2020](#ref-rstudioteam2020)) and the appropriate packages. To ensure the complete transparency and reproducibility of this article, the lead author (M.O.) uploaded all data used to generate this article on Open Science Framework (DOI : [masked for the anonymity of the review])

Our main research question was : *“What is known about Syndemic Theory applied to MSM”* was subdivided into three sub-questions :

1. *“How are studies concerning Syndemic Theory applied to MSM conducted ?”*;
2. *“How is the concept of interaction explored in syndemic research applied to MSM ?”* and
3. *“What were the key findings of these studies ?”*.

To answer these questions, we conducted a systematic search strategy in the following databases : Medline, PsycInfo, Scopus, Cochrane Central Register of Controlled Trials and ProQuest Sociological Abstracts using complex search equations to include every synonym for “men who have sex with men”. The complete search strategy for each database can be found in the Supplementary Material of our protocol. No date limit was applied given the relative novelty of the syndemic literature. A first search using this strategy was conducted the 11th of June 2020 and was subsequently updated on the 9th of February 2021 and finally on the 11th of November 2021.

Search results were downloaded into .RIS files and imported into DistillerSR. After duplicate removal, we screened the title and abstracts for eligibility, using forms generated with DistillerSR by the authors. Articles that met the inclusion criteria or for which eligibility was unclear underwent a second screening in which the full texts were assessed for eligibility. As per the protocol, 10% of the titles and abstracts were screened by two reviewers. A Kappa inter-rater reliability score was computed using DistillerSR and was equal to 0.86. As it exceeded our cutoff of 0.8, the rest of the screening process was conducted by the main investigator only. Articles were included if they met the following criteria:

* MSM was either the only population studied in the paper or, if studied alongside other populations, such as transgender women, disaggregated data must have been available for MSM
* Syndemic framework was the main focus of the study
* Studies were cohort, case-control, cross-sectional, controlled trials, mixed studies, qualitative studies, systematic reviews or meta-analyses. We excluded letters, commentaries, conference abstracts, editorials or narrative reviews
* Language was English
* The article was published in a peer-reviewed journal

After inclusion of relevant studies, we hand-searched the reference lists to manually add pertinent studies. The same selection process was then applied, and these papers are marked as “Additional records identified through other sources” in the study selection flow diagram (Figure ).

Data charting was also performed using forms generated in DistillerSR by the authors. The complete list of all variables for which data were sought can be found in our protocol [Anonymous 2020]. Furthermore, the README file of our *Data* subdirectory contains an exhaustive definition of every variable included. Two amendments were made to our initial protocol:

1. We included a variable to chart any additional frameworks the authors might have used
2. We included variables to chart data for systematic reviews and meta-analyses. These two kinds of studies were omitted from our initial protocol as we were not aware of the existence of systematic reviews on syndemic theory applied to MSM by the time we published the protocol. The variables included were general characteristics (authors, year, location, design, total sample size), purpose of the review, number of studies included, hypothesis for biological or bio-social interaction, key findings and additional frameworks.

Data were then collated, summarised and reported using R, RStudio and relevant packages. Charts were generated to better visualize year of publication, location, population and syndemic conditions studied. Tables were generated to summarise the main variables of every article as well as the measurement methods of the most studied syndemic conditions. These tables can be found respectively in part B and C of the supplementary materials of this paper. Additionally, we generated an online report accessible at <https://datastudio.google.com/u/0/reporting/56c1e17a-fa3f-47e9-9516-d3d0eef7ec1> This report contains all studies included in the review and provides researchers in the field the opportunity to search relevant studies using multiple filters.

# Results

This section summarizes the findings relevant to our research questions. , and in the supplementary material, summarize every reference identified and the variables extracted to answer our research questions for quantitative studies, qualitative studies and reviews, respectively.

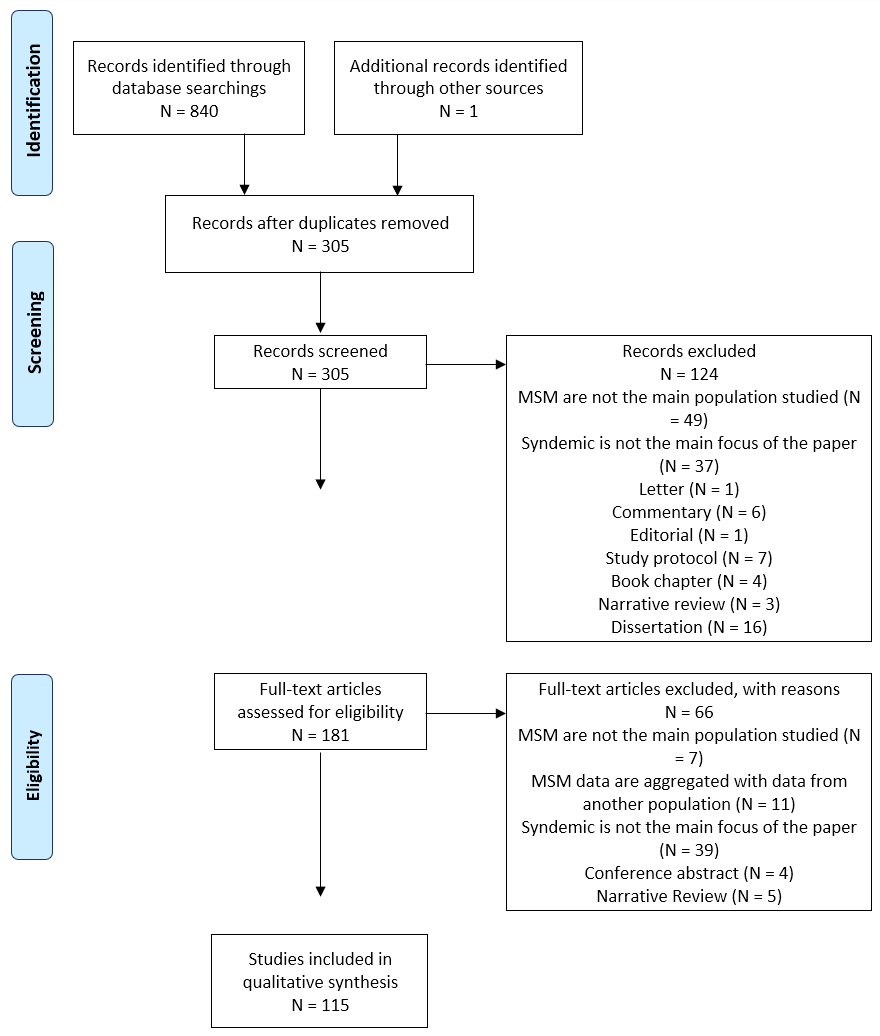
## Literature search

The electronic search identified 840 references and our handsearch of reference lists resulted in the addition of the seminal study by Stall and colleague ([Stall et al., 2003](#ref-Stall2003)). After removing duplicates, 305 records were screened for inclusion.

After screening the title and abstract, 124 records were excluded. The two main reasons for exclusion at this stage were that MSM were not the main study population (n=49) and that syndemic was not the main focus of the paper (n=37). Thirty-eight studies were excluded because the type of publication did not meet our inclusion criteria.

The full texts of the 181 remaining references were obtained and read; 66 were excluded after this phase. During the previous step, we had decided to tentatively include papers in which the sample was not entirely comprised of MSM. After reviewing the full paper, we decided to exclude studies if the MSM data were aggregated with data from another population (n=11), most commonly transgender women. The rationale for this decision was to keep the focus clearly on MSM.

The PRISMA flowchart generated by DistillerSR can be found in Figure

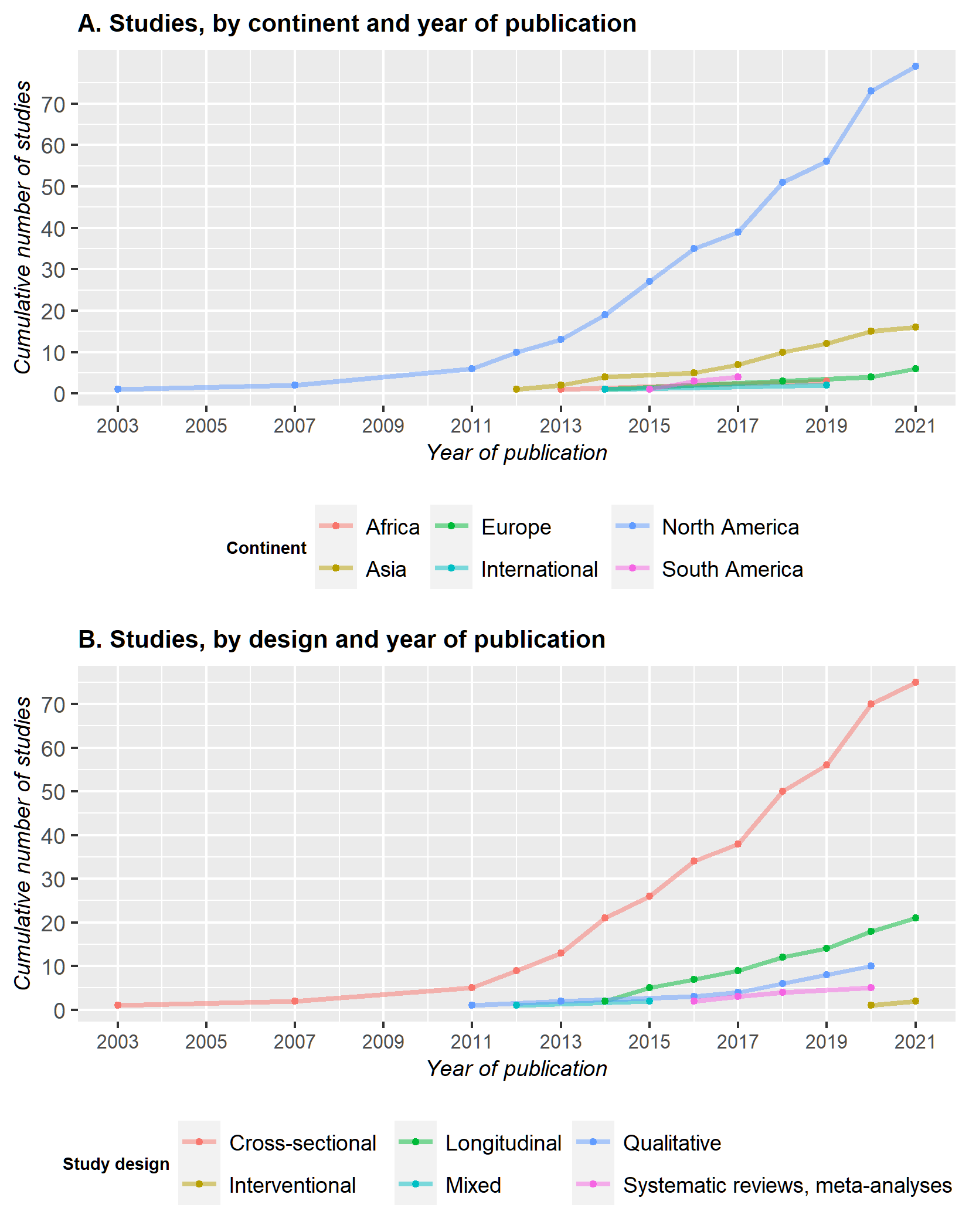


**Figure** : PRISMA flowchart of the search strategy

## How are studies concerning Syndemic Theory applied to MSM conducted?

### General characteristics of included studies

The publication date of the studies ranges from 2003 to 2021 with a marked increase in the number papers published annually from 2013 onward as illustrated in Figure . There is also an increase in the diversity of the studies, both in the study design used and the continents where the studies were conducted.



**Figure** : Plot of the cumulative number of studies published yearly

However, despite the increasing diversity, the vast majority of the studies were conducted in North America (N = 79), with a large predominance of studies in the USA (N= 67). The majority of the remaining studies were then located in Asia (N = 16) or in Europe (N = 6). South America (N = 4) and Africa (N = 3) are the least represented continents.

In terms of design, a similar pattern appears, with most of the studies employing a cross-sectional design (N = 75). The number of longitudinal studies has grown steadily since 2014 and represents 18% of the papers. The duration of longitudinal studies ranged from 6 to 120 months.

Compared to quantitative studies, qualitative studies are under-represented, with only 10 papers. In terms of analysis method, the most common is thematic (content) analysis (N= 5). The rest of the studies consists of framework analysis (N = 2), grounded theory (N = 1), analytic induction (N = 1) and constant comparative analysis (N = 1).

We identified 2 papers employing mixed methods design ([Buttram and Kurtz, 2015](#ref-buttram2015); [Halkitis et al., 2012](#ref-Halkitis2012)); Buttram et al. used a cross-sectional design for the quantitative part and in-depth interviews analyzed through grounded theory for the qualitative part while Halkitis et al used a cross-sectional quantitative survey and in-depth discovery interviews.

The first systematic reviews and meta-analyses were published in 2016, while the first interventional studies were published in 2020.

Finally, the median sample size of the studies is 454.5 (range: 15 - 24 274) and the mean age of the participants, when reported, ranges from 16 to 58 years.

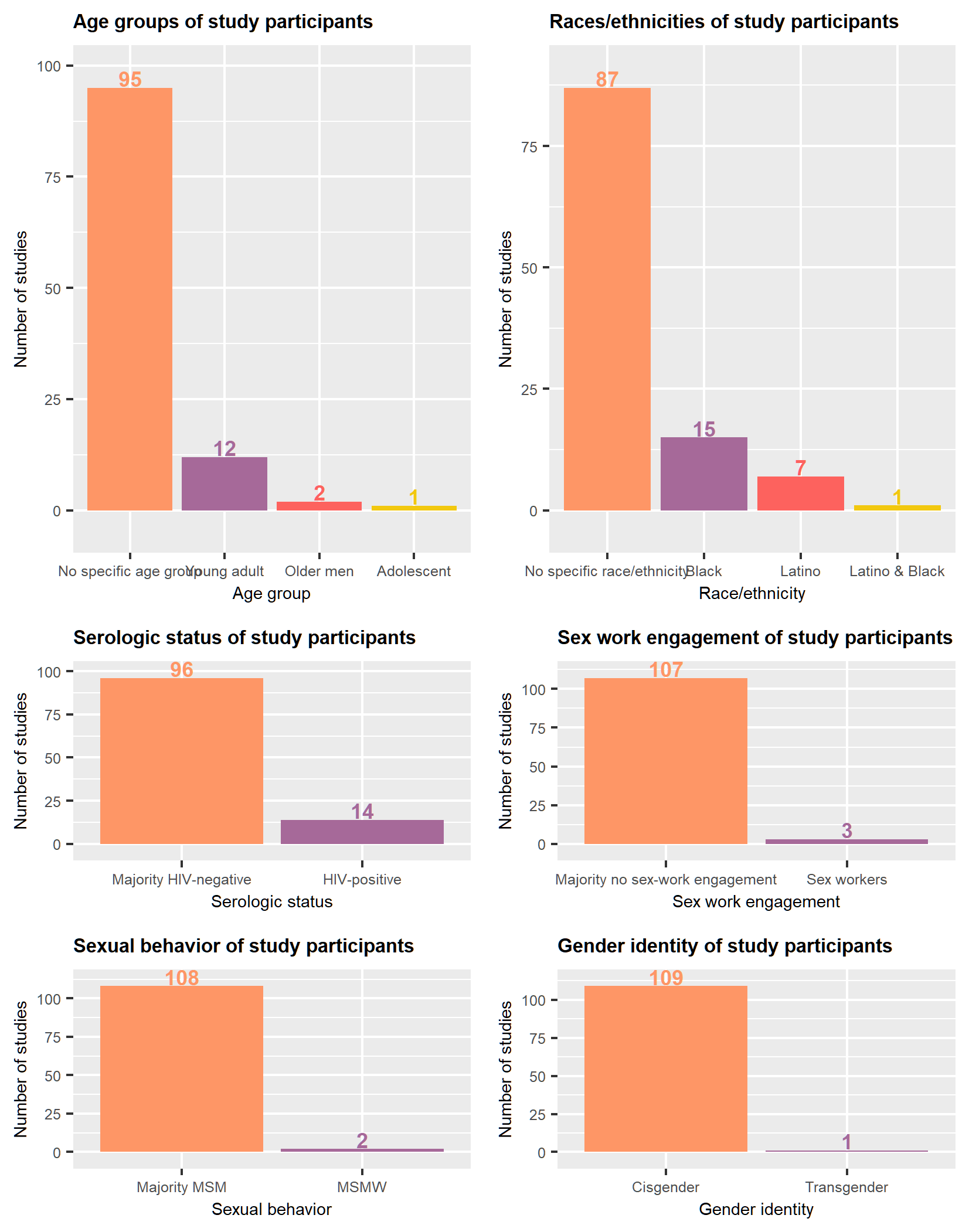
### Subpopulations studied

Less than half of the studies (N = 51 ) focus on a subpopulation of MSM ; of those, we identified seven types of MSM subpopulations : (a) young MSM; (b) older MSM; (c) MSM from a racial/ethnic minority; (d) MSM living with HIV; (e) MSM engaged in sex work; (f) Men who have Sex with Men and Women (MSMW); and (g) transgender MSM.  
Among studies focusing on a specific age group, 12 studies focus on young adults, 2 studies focus on older MSM([Halkitis et al., 2012](#ref-Halkitis2012); [Zepf et al., 2020](#ref-zepf2020)) and 1 study focuses on adolescents([Perry et al., 2019](#ref-Perry)).  
Black MSM (BMSM) are the most studied MSM from a racial/ethnic minority (N= 15) but studies focusing on them still represent only 14% of our sample.  
7 studies focus on Latino MSM (LMSM) and 1 study focus on both BMSM and LMSM([Cassels et al., 2020](#ref-cassels2020)).

Concerning the serologic status of MSM in syndemic literature, 14 studies are entirely comprised of a sample of MSM living with HIV. Notably, we didn’t identify any studies focusing on racial minority MSM living with HIV.  
Finally, the least represented subpopulation of MSM in this review are MSM engaged in sex work (N = 3), MSMW (N = 2) and transgender MSM (N = 1).

Figure gives a visual representation of MSM subpopulation’s representation in the studies included in this paper.

In order to obtain the most comprehensive knowledge of the representation of MSM subpopulations in syndemic literature, we also took into account studies that do not focus on any subpopulation in particular but present disaggregated data and analyses for one or more MSM subpopulations.  
8 studies present such data : 1 for Black MSMW([Dyer et al., 2020](#ref-dyer2020)), 4 for MSMW([Branstrom and Pachankis, n.d.](#ref-branstrom); [Ferlatte et al., 2018b](#ref-ferlatte2018); [Friedman et al., 2014](#ref-friedman2014); [Mustanski et al., 2014](#ref-Mustanski2014)), 2 for MSM living with HIV([Kurtz et al., 2012](#ref-Kurtz2012); [Ng et al., 2020](#ref-ng2020)) and 1 for Latino and Black MSM([Mustanski et al., 2017](#ref-Mustanski2017)).



**Figure** : Number of studies focusing on a MSM subpopulation

### Syndemic conditions and their measurement

#### Number and type of syndemic conditions identified

We identified 46 different syndemic conditions in the 100 quantitative studies we included.

The health-related conditions we identified are : depression (N = 80), alcohol use disorder (AUD) (N = 21), sexual compulsivity (N = 19), suicidal thoughts and/or attempts (N = 16), anxiety (N = 15), substance use disorder (SUD) (N = 14), post-traumatic stress disorder (PTSD) (N = 10), general mental distress (N = 5), internalised homophobia (N = 4), low self-esteem (N = 4), sexually transmitted infections (STI) (N = 3), involuntary subordination (N = 2), HIV diagnosis (N = 3), hostility (N = 2), stress (N = 2), experience of trauma (N = 2), alexithymia (N = 1), attention deficit hyperactivity disorder (ADHD) (N = 1), cognitive escape (N = 1), hypersexuality (N = 1), impulsivity (N = 1), poor physical health (N = 1) and sleep disturbance (N = 1).

Alongside these health-related conditions, we also identified numerous social conditions : substance use (N = 48), intimate partner violence (IPV) (N = 47), childhood sexual abuse (CSA) (N = 37), polysubstance use (N = 27) , binge drinking (N = 22), experiences of violence (N = 17), sexual risk behaviors (N = 15), alcohol use (N = 12), discrimination (N = 10), chemsex (N = 7), loneliness (N = 6), incarceration (N = 5), unstable housing (N = 5), tobacco use (N = 5), childhood abuse (N = 4), low social support (N = 4), exchange sex (N = 3), intravenous drug use (IDU) (N = 2), poverty (N = 2), unemployment (N = 2), poor healthcare access (N = 2), frequenting gay social venues (N = 1) and school bullying (N = 1).

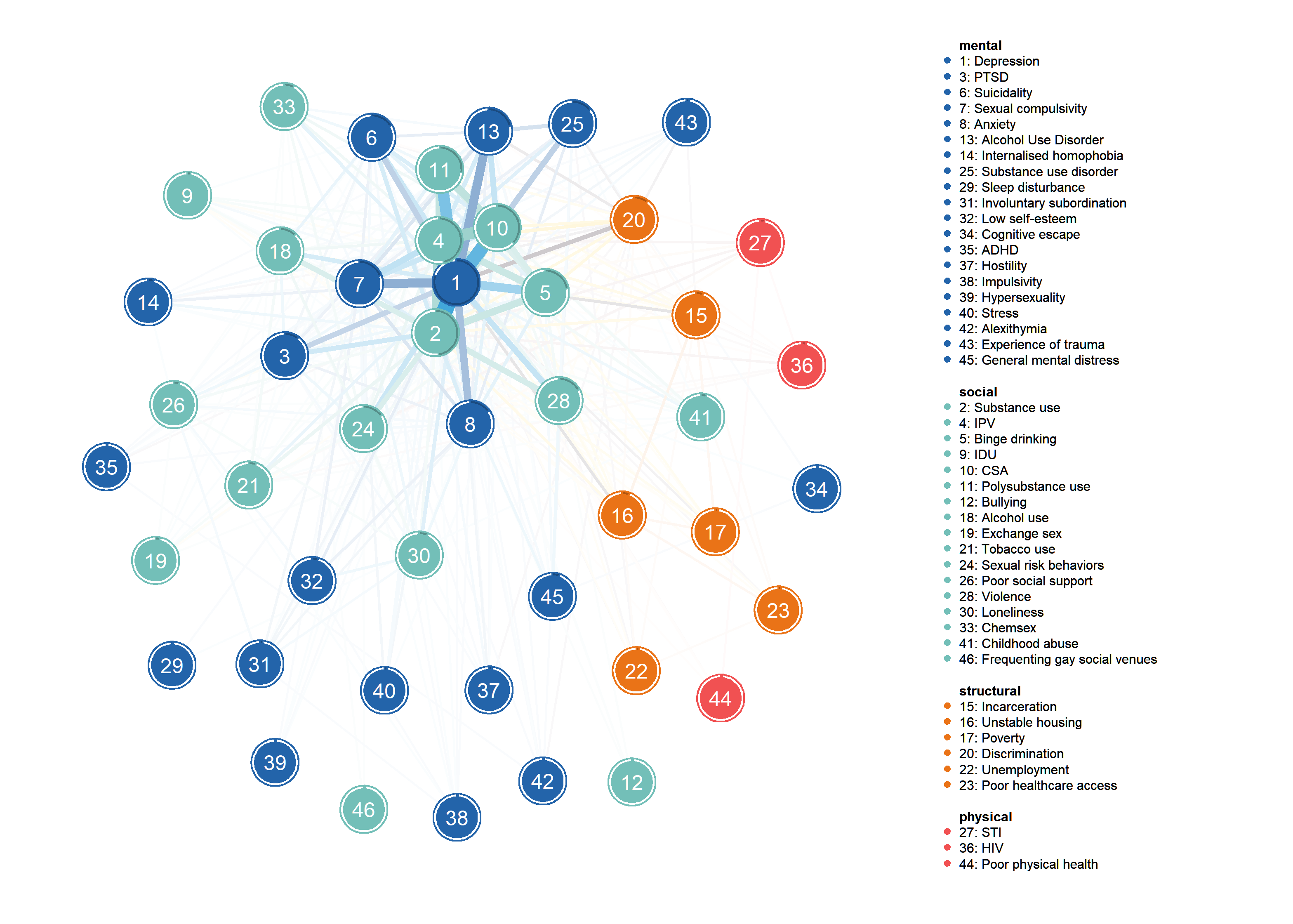
We chose to distinguish between AUD, binge drinking and alcohol use instead of merging them into a broad ‘alcohol-related syndemic condition’. Some authors also considered ‘heavy drinking’ ([Martinez et al., 2020](#ref-martinez2020); [Martinez et al., 2016](#ref-Martinez2016a)) or ‘heavy alcohol use’([Mimiaga et al., 2015](#ref-Mimiaga2015b)) but we chose to aggregate these conditions under ‘binge drinking’ for clarity. Similarly, we distinguish between substance use, substance use disorder, intravenous drug use, polysubstance use, marijuana use, tobacco use and chemsex since they differ in terms of potential harm and the context of use.

#### Network analysis of the syndemic conditions

In order to better understand the connections between the syndemic conditions in the studies we elaborated a network plot (Figure ). Nodes represent the syndemic conditions studied in the literature and edges (connectors) are drawn between two nodes when two conditions are studied in the same research paper. Edges between nodes are thicker if the two conditions are frequently studied together and the outline of the nodes represent pie chart of their frequency in syndemic literature. For example, depression, the most studied condition, appears in 80% of our sample. As such, the node is circled by a chart representing this proportion. Moreover, as a force-directed graph, the location of the nodes gives an indication regarding their importance in terms of frequency and linkage to other conditions. As such, depression occupies a more central position than ADHD which was only studied once.

In this figure, we divided the conditions studied into four categories: mental health (e.g. depression, anxiety, PTSD) in blue, social conditions (e.g. substance use, loneliness) in teal, structural conditions (e.g. unemployment, healthcare access) in orange and physical health (e.g. STI, HIV) in red. The figure shows that structural syndemic conditions and physical health-related syndemic conditions are much less central, therefore much less studied, than social syndemic conditions and mental health-related syndemic conditions which are located towards the center of the figure.

Regarding the edges of the network, we identified 341 pairs of syndemic conditions. However, nearly half of these pairs of conditions (N = 156) appear in only one research paper. On the other hand, the most studied pairs of syndemic conditions were depression and IPV (N = 37), depression and substance use (N = (N = 36), depression and CSA (N = 30), IPV and CSA (N = 26) and depression and polysubstance use (N = 25).



**Figure** : Network of the syndemic conditions studied in quantitative research. As a force-directed network, the most studied and interconnected conditions are the most central. Additionally, each node is circled by a pie chart of their frequency in the review. The thickness of the edges linking two nodes reflects the number of studies in which the two conditions were studied together.

#### Measurement of the syndemic conditions

The next part of our research question was to examine the way the syndemic conditions were studied in the literature. For the most often studied syndemic conditions, we found a high degree of variability in their measurement. Different authors used different scales or criteria and, even when the same scale or criteria was used, the cutoff or reference period differed among studies. For the sake of brevity, we will only provide a detailed description of the measurement method for the five most studied syndemic conditions. Detailed information on the syndemic conditions most impacted by methodology heterogeneity is presented in the supplementary material, part C ( to ).

For depression, 20 different scales or criteria are used among the 80 studies in which this condition was studied. The most frequently used scales are the full Center for Epidemiologic Studies-Depression scale (CESD) (N = 26) and the 10-item version of this scale (CESD-10) (N=11), the 9-item version of the Patient Health Questionnaire (PHQ-9) (N=9) and the Beck Depression Inventory (BDI-II) (N = 5).  
Cutoff for these scales varied the most for the CESD (range : 16 to 27) and the PHQ-9 (range : 5 to 15).  
When a scale is not used, the most frequent criteria to assess the presence of depression is the participant being on medication for depression in the past 12 months (N = 4).

For substance use, we looked at the class of substances explicitly screened by the authors and the reference period used. The most frequently screened class of substance is stimulants (i.e. cocaine/crack, amphetamines ; N = 42), followed by depressants (i.e. GHB/GBL, benzodiazepines without prescriptions ; (N = 21), opioids (i.e. opioids misuse and heroin ; N = 21), marijuana (N = 18), ecstasy /MDMA (N = 18), hallucinogens (i.e. ketamine, psilocybine, phencyclidine; N = 18), inhalants (nitrous oxyde, poppers; N = 15) and new psychoactive substances (i.e. synthetic cannabinoids, cathinones; N = 3).  
Reference periods range from the past month to over the lifetime.

For polysubstance use, 18 studies consider that there is polysubstance use when three or more classes of substances are used while nine studies define polysubstance use as more than one class of substance being used. Furthermore, six studies exclude marijuana from the class of substances screened and two studies exclude stimulants, because stimulants were already screened in another syndemic condition.

Five types of IPV were identified : physical violence (N = 38), psychological violence (N = 25), sexual violence (N = 23), gay-related violence (e.g. threats to reveal the partner’s sexual orientation ; N = 3) and HIV-related violence (e.g. threats to disclose the partner’s serologic status ; N = 1). Reference periods vary from the past month to over the lifetime.

For CSA, we identified 14 different definitions and 3 scales among the 37 studies. The various definitions differ regarding the age at which sexual intercourse occurred to be qualified as childhood sexual abuse, the age gap between the victim and the perpetrator and whether the sexual intercourse was unwanted. The most frequent definition is Finkelhor’s definition([Finkelhor, 1994](#ref-finkelhor1994)): any sexual experience before 13 years old with someone at least five years older or any sexual experience between 13 and 17 years old with someone at least ten years older (N = 7).

### Outcomes and their measurement

We identified 22 different outcomes in our sample of quantitative studies. Sexual risk behavior is the most frequently studied outcome, appearing in 60 research papers. The second most studied outcome is HIV diagnosis (N = 20), followed by STI diagnosis (N = 10), adherence to antiretroviral therapy (N = 6), pre-exposure prophylaxis (PrEP) use (N = 4), healthcare use (N = 4) and the syndemic conditions themselves (N = 4). Less often, researchers also use viral load (N = 3), suicidality (N = 3) or engaging in exchange sex (N = 3) as outcomes.

Every other outcome is only studied once: HIV screening ([Cristian J. Chandler et al., 2020a](#ref-Chandler2019b)), HIV transmission ([Satyanarayana et al., 2021](#ref-satyanarayana2021)), engagement in HIV care ([Biello et al., 2016](#ref-Biello2016)), sexual violence ([Semple et al., 2017](#ref-semple2017)), substance use ([Turpin et al., 2020](#ref-turpin2020)), engagement in chemsex ([Friedman et al., 2014](#ref-friedman2014)), having sexual intercourse with both men and women ([Eaton et al., 2013](#ref-eaton2013)) , help-seeking behaviors ([Achterbergh et al., 2021](#ref-achterbergh2021)), physical activity ([Zhang et al., 2019](#ref-Zhang2019)), glycemic control ([Byg et al., 2016](#ref-Byg2016)), hypothalamic-pituitary-adrenal (HPA) axis dysregulation ([Carrico et al., 2018](#ref-carrico2018)) and elevation in rectal cytokines/chemokines ([Tapia et al., 2021](#ref-tapia2021)).

There is a high degree of variability in the definition of what constitutes sexual risk behaviors though the most frequently used proxy is, by far, condomless anal sex (N = 57).

Used in conjunction with condomless anal sex, other proxies for sexual risk are number of partners (N = 11), substance use during sex (N = 3), condomless vaginal sex (N = 2), condomless oral sex (N = 1), sexual intercourse with female partners (N = 1), engaging in group sex (N = 1) and non-disclosure of HIV serostatus before first sexual intercourse with current main partner (N = 1).

When HIV is used as an outcome, it is self-reported in more than half of the studies (11 studies out of 20) Similarly, for STI diagnosis, self-reporting is used in 5 papers out of 10.

### Interventions

We identified only 2 interventional studies guided by syndemic theory ([Achterbergh et al., 2021](#ref-achterbergh2021); [Chakrapani et al., 2020](#ref-Chakrapani)). Chakrapani et al. used a pre-test/post-test non-equivalent group design and the intervention consisted of motivational interviews. The goal of this intervention was to reduce condomless anal intercourse by enhancing condom self-efficacy and addressing co-occurring syndemic conditions.

Achterbergh et al. conducted a randomized controlled trial and the intervention consisted of tailored feedback and help-seeking advice on mental health screening. The primary endpoint was to increase help-seeking behaviors; the secondary endpoints were reducing sexual risk behavior and STI incidence.

The intervention lasted for 12 months in both studies.

In Chakrapani et al. the intervention was successful in reducing the psychosocial conditions investigated (depression, alcohol use and internalised homophobia) and improving condom use. Furthermore, synergy, as measured by interaction on the additive and multiplicative scales, is present for depression and alcohol use as well as for depression and internalised homophobia on inconsistent condom use. Finally, a mediation analysis revealed that the improvement in consistent condom use was due to an improvement in condom self-efficacy caused by a reduction in alcohol use and internalised homophobia.

On the other hand, the RCT conducted by Achterbergh et al. failed to impact the primary endpoint nor the two secondary endpoints.

### Summary of reviews

We identified 3 systematic reviews ([Lassiter and Parsons, 2016](#ref-Lassiter2016); [Lewis and Wilson, 2017](#ref-lewis2017); [Woodward et al., 2017](#ref-woodward2017)) and two meta-analyses ([Pantalone et al., 2020](#ref-Pantalone2020); [Rooney et al., 2018](#ref-Rooney2018a)) in our review.

Woodward et al. aimed to identify a set of resilience resources among MSM burdened with minority stress and psychosocial condition in order to improve HIV prevention ([Woodward et al., 2017](#ref-woodward2017)). They included 20 studies in their reviews and identified 31 resilience resources, with social support and financial incomes as the two most frequently cited. Of note, most of these resources are associated with a lower HIV risk.

Lassiter et al. aimed to propose a framework to include religion and spirituality into HIV research with MSM ([Lassiter and Parsons, 2016](#ref-Lassiter2016)). They found that religion and spirituality had mixed effect on syndemic conditions but could be more beneficial for MSM of color than for white MSM. Of note, the review is relatively small (including 9 studies) as these two factors are very sparse in syndemic literature.

Lewis and Wilson sought to examine the HIV prevalence and associated risk behaviors among migrant and ethnic minority MSM in North America and Europe ([Lewis and Wilson, 2017](#ref-lewis2017)). They found high rates of HIV prevalence and associated risk factors and propose that transnational migration could be part of a syndemic.

In their meta-analysis, Rooney et al. studied the syndemic conditions associated with sexual compulsivity among MSM and computed the mean effect size as well as whether this effect varied as a function of the type of syndemic conditions associated ([Rooney et al., 2018](#ref-Rooney2018a)). They included 36 papers and found that sexual compulsivity was significantly associated with 7 syndemic conditions (anxiety, depression, CSA, alcohol use, substance use, IPV and sexual risk behaviors). The two strongest associations were with depression and anxiety.

Finally, Pantalone et al. sought to have a better understanding of the state of interventions co-targeting interconnected syndemic conditions and HIV-related health behaviors of MSM ([Pantalone et al., 2020](#ref-Pantalone2020)). They included 43 studies and found a small significant positive effect of combined behavioral interventions to improve mental health, substance use, alcohol use and sexual risk behaviors, with significant heterogeneity. Interestingly, a greater number of sessions (at least 9) and individual rather than group interventions showed greater efficacy.

### Additional frameworks used in the studies

Twenty studies use an additional framework alongside syndemic theory. The most widely used is resilience theory (N = 10), followed by minority stress model (N = 5), intersectionality (N=2), social-cognitive theory (N=2), salutogenesis (N=1) and ecological framework (N=1).

## How is the concept of interaction explored in syndemic research applied to MSM?

### Statistics used to show an interaction

It should be stated that, when we speak of an interaction between syndemic conditions we do not necessarily mean ‘synergy’, though synergy is indeed one of the interactions we consider. Drawing from the works of authors such as Tsai and Chakrapani, we consider three types of interaction : synergistically interacting epidemics, serially causal epidemics and mutually causal epidemics ([Chakrapani et al., 2019b](#ref-Chakrapani2019); [Tsai, 2018](#ref-Tsai2018a)). As such, statistical methods such as mediation analysis, path analysis or structural equation modeling are also considered.  
Our review reveals a high degree of variability in the statistical analyses. The most frequently used statistical method is regression analysis using a summation score of the syndemic conditions (N = 68). Among studies employing this method, 45 do not use any other method to determine the degree of interaction between syndemic conditions.  
In comparison, only 13 studies tried to evaluate departure from additivity on the additive and/or multiplicative scales, as recommended by Tsai ([Tsai and Burns, 2015](#ref-tsai2015)) to demonstrate synergy between syndemic conditions. Examples of measures for assessing departure from additivity are relative excess risk due to interaction (RERI), attributable proportion due to interaction (AP), and the synergy index (S).  
Furthermore, some studies sought to obtain a better understanding on the mechanism of interaction between the syndemic conditions and the outcome by using mediation analysis (N = 12), moderation analysis (N = 8), Structural Equation Modeling (N = 7) or path analysis (N = 1).  
Additionally, 8 studies use latent variables modeling such as Exploratory/Confirmatory Factor Analysis, Latent Profile Analysis, Latent Class Analysis or Latent Transition Analysis.  
Using a different approach, 2 studies conducted by Lee and colleagues ([J. S. Lee et al., 2020](#ref-lee2020); [Jasper S. Lee et al., 2020](#ref-Lee)) use network analysis, in which syndemic is conceptualized as a network and the syndemic conditions as interconnected nodes reinforcing each others.  
Finally, other statistic analysis use to assess interaction are observed/expected ratio (N = 2), cluster analysis (N = 1), point-biserial correlation matrix (N= 1) and synergy factor analysis (N=1).

### Proposed mechanisms of interaction

In our sample of quantitative studies, we found only one study offering a mechanism of biological interaction ([Carrico et al., 2018](#ref-carrico2018)) and two studies offering a mechanism of bio-social interaction ([Klein, 2011](#ref-Klein2011); [Tapia et al., 2021](#ref-tapia2021)).

Carrico et al. showed that the combined effects of HIV infection and methamphetamine use are detrimental for the functioning of the Hypothalamic-Pituitary-Adrenal axis which is thought to play an important role in the reinforcing effect of stimulants.

Klein proposed that attitudes toward condom use is one of the key factors contributing to condomless sex and, subsequently, HIV infection. In their study, attitudes toward condoms are predicted by low self-esteem, as condom use represents a self-protecting mechanism, as well as by sexual preferences, substance use, race and education. Furthermore, childhood emotional neglect has a negative influence on self-esteem thus indirectly contributing to sexual risk taking.

Finally, Tapia et al. demonstrated that a higher number of syndemic conditions are associated with elevation in rectal cytokines/chemokines relevant to HIV/STI transmission. This finding presents a pathway through which depression, alcohol use disorder, substance use and PTSD may increase the biological susceptibility to HIV/STI. Unfortunately, using solely a summation score to conduct regression analysis, no synergy between the conditions is evaluated.

Qualitative studies propose mechanisms of bio-social interaction more often than quantitative studies. We identified 5 papers with such hypothesis of interaction ([Chakrapani et al., 2019a](#ref-Chakrapani2019a); [Lyons et al., 2013](#ref-Lyons2013); [Maiorana et al., 2020](#ref-Maiorana); [Pollard et al., 2018](#ref-Pollard2018a); [Quinn, 2019](#ref-Quinn)) . On the other hand, we did not find any qualitative paper exploring biological interaction.

Stigma and structural inequalities are indicated by the five papers as the root causes of syndemic conditions and HIV risk behaviors. Maionara et al. showed that economic dependency and fear of violence may maintain YBMSM in dysfunctional relationships plagued by IPV and substance abuse which increase their odds of incarceration and HIV infection ([Maiorana et al., 2020](#ref-Maiorana)). Furthermore, methamphetamine is used as a coping strategy while simultaneously representing a potential factor in acquiring or transmitting HIV to others, notably during sex parties.

This finding of substance use as a coping mechanism is supported by the study by Pollard et al. who found that maladaptive coping strategies to minority stress and the performative resistant space of the gay scene contributed to chemsex use ([Pollard et al., 2018](#ref-Pollard2018a)).

For Black MSM, other sources of structural violence such as racial neighborhood segregation contribute, alongside poverty, unemployment, violence, unstable housing, incarceration and poor healthcare access to expectations surrounding masculinity which may conflict with the sexual orientation of BMSM, leading to internalised homophobia ([Quinn, 2019](#ref-Quinn)). Internalised homophobia, in turn, may lead to poor mental health as well as to substance abuse and sexual risk taking as coping mechanisms. Moreover, the use of PrEP, perceived as a ‘gay pill’ may negatively impact the use of PrEP in this community. Lyons et al. also showed that the marginalization of YMSM within their school, communities of origin and families resulted in a lack of gay-specific HIV prevention education, role-model and productive goal-related activities ([Lyons et al., 2013](#ref-Lyons2013)). The HIV-positive MSM youth in this study linked these factors to their HIV acquisition. Finally, ([Chakrapani et al., 2019a](#ref-Chakrapani2019a)) showed the role of family support and communities of MSM to serve as resilience resource to counteract the negative effects of stigma and syndemic conditions.

## What were the key findings of these studies?

In nearly all of the quantitative studies, the syndemic conditions chosen by the authors are associated with the outcomes of interest.

However, some interesting discrepancies in the findings were found. On the topic of synergy, results are conflicting between studies. The findings of Chakrapani and colleagues support the three models of interacting epidemics (synergistically interacting epidemics, serially causal epidemics and mutually causal epidemics) with the strongest support for the model of synergistically interacting epidemics ([Chakrapani et al., 2019b](#ref-Chakrapani2019)). These findings are supported by other studies who found synergy through departure from additivity, by using measures such as RERI, AP or S, or through departure from multiplicativity by using significant product terms in the multiplicative scale ([Bulled, 2021](#ref-bulled2021); [Chakrapani et al., 2020](#ref-Chakrapani); [Cristian J. Chandler et al., 2020c](#ref-chandler2020); [Cristian J. Chandler et al., 2020b](#ref-Chandler2019); [Chuang et al., 2021](#ref-chuang2021); [Tomori et al., 2018](#ref-tomori2018)). However, other studies found no synergy between the syndemic conditions using the same statistical approach ([Batchelder et al., 2019](#ref-Batchelder2019); [Ferlatte et al., 2018a](#ref-Ferlatte2018a); [Shuper et al., 2020](#ref-shuper2020)).

Conflicting results are also present for MSMW. Brandstrom and Pachankis found no clustering of syndemic conditions for MSMW ([Bränström and Pachankis, 2018](#ref-Branstrom2018)) while Mustanski et al. found a stronger clustering of syndemic conditions in YMSMW compared to YMSM ([Mustanski et al., 2014](#ref-Mustanski2014)). Furthermore, Black MSM in the study by Dyer et al. suffered from a higher burden of STI than Black MSMW ([Dyer et al., 2020](#ref-dyer2020)). Ferlatte found more syndemic conditions in the MSM compared to the MSMW ([Ferlatte et al., 2018b](#ref-ferlatte2018)), mainly driven by party drug use and treatment for depression or anxiety. Finally, in a sample of Latino MSMW, having two syndemic conditions predicted receptive condomless anal sex and STI diagnosis but not insertive nor vaginal condomless sex ([Muñoz-Laboy et al., 2018](#ref-Munoz-Laboy2018)).

In a longitudinal study ([Mustanski et al., 2017](#ref-Mustanski2017)) Black MSM were found to have the highest HIV incidence while having a lower burden of syndemic condition than White MSM, raising the question of the need to focus on syndemic conditions specific to Black MSM. Interestingly, Bulled observed a synergy only for White MSM in their reanalysis of Stall’s data ([Bulled, 2021](#ref-bulled2021)). The authors proposed that, for racial minority MSM, structural disadvantage limiting access to healthcare may be more important than substance use and violence.

While condomless anal sex is often used as a proxy for the risk of acquiring HIV or another STI, the findings of some studies tend to show some limitation of this proxy. For example, Moeller et al. found an association between syndemic conditions and condomless anal sex but not with HIV diagnosis ([Moeller et al., n.d.](#ref-moeller)). A similar pattern appears in a longitudinal study that found an association between syndemic conditions and sexual risk behaviors but not with HIV or STI incidence ([Mustanski et al., 2017](#ref-Mustanski2017)). On the other hand, some authors found an association between syndemic conditions and HIV but not with condom use ([Chuang et al., 2018](#ref-chuang2018)).

Alcohol misuse is inconsistently linked to risk taking. Card et al found no association between the AUDIT score and sexual risk behaviors ([Card et al., 2018](#ref-Card2018)) while another study using latent class analysis found that the class with alcohol misuse has a lower level of risk behaviors ([Scheer et al., 2021](#ref-scheer2021)). Nonetheless, alcohol misuse is associated with PrEP non-adherence ([Shuper et al., 2020](#ref-shuper2020)).

# Discussion

The objective of this scoping review was to map the current knowledge on syndemic research applied to MSM. To this end, we analysed 115 articles and found that the literature was both too homogeneous in some aspects while being not focused enough in other aspects. As we will discuss in more depth below, the location, design, subpopulations and outcomes lacked diversity. On the other hand, the syndemic conditions and ways of measurement were not standardised enough to ensure the robustness, reproducibility and comparability of the findings. Furthermore, a substantial part of the literature doesn’t provide empirical data to support one of the core tenets of syndemic theory - namely disease interaction- as has been pointed out in a previous review ([Tsai and Burns, 2015](#ref-tsai2015)).

## Location

The location of study is an aspect of syndemic literature suffering from too much homogeneity. Indeed 72% of studies are conducted in North America alone while all studies conducted in the Global South represents only 21% of our sample.

Three issues arise from this. First, under-representation of the Global South compromises our understanding of the health of MSM living in these countries. Furthermore, as pointed out by ([Weaver and Kaiser, 2020](#ref-weaver2020)), the screening tool used to assess the presence of a syndemic condition in the Western context may not be efficient in another sociocultural setting, especially regarding mental health. As syndemics are driven by the sociocultural forces of a given place at a given time, these potential biases need to be addressed in order to conduct meaningful research outside Europe and North America.

Moreover, even for studies conducted in Europe and North America, a large portion of the studies conflate data from different cities, counties, states or even countries in order to obtain a sample big enough to conduct statistical analyses. However, geographical variations in syndemic burden are likely to be missed. Migration of MSM to larger cities is a well-known phenomenon and thought to be an important part of syndemic production among MSM as well as a source of resilience ([Bruce et al., 2011](#ref-Bruce2011); [Stall et al., 2007](#ref-stall2007)). Differences in the density of gay social venues and peer organizations as well as exposure to discrimination and violence or an easier access to substances need to be taken into account when studying a syndemic. As Shresta et al. suggested, syndemic research needs to incorporate data from spatial epidemiology to better understand the interactions of socioeconomic forces in the physical space and how these forces can influence the health of populations ([Shrestha et al., 2020](#ref-shrestha2020)). In their paper, they illustrated their framework with a ‘syringe-based syndemic’ of HCV, HIV, and opioid-related deaths in West Virginia and examined how variables related to unique physical space such as local drug availability drove this syndemic.

## Design

The design of syndemic studies is another element suffering from a lack of diversity. The field is dominated by quantitative studies as qualitative papers represent only 9% of our sample. Moreover 75% of the quantitative studies were cross-sectional. As vulnerability to syndemic conditions is suspected to arise from early adverse experience ([Stall et al., 2007](#ref-stall2007)) longitudinal studies running over a long period of time are probably needed to study syndemic production among MSM.

Moreover, as shown in our result, qualitative papers are more prone to discuss the potential interactions between syndemic conditions. Some concepts and experiences needed to understand syndemic production in MSM can only be studied through a qualitative approach. For example, the complex narratives surrounding drug use and its link to loneliness, marginalization, personal affirmation, resistance and lack of meaningful emotional connections ([Pollard et al., 2018](#ref-Pollard2018a)) would be hard to measure and model using quantitative data. As Tsai previously pointed out, the inevitable simplification needed to estimate statistical models may lead to an over-simplification of diseases dynamics ([Tsai, 2018](#ref-Tsai2018a)). Mixed methods studies are needed to complement robust statistical estimation with insights on sociocultural mechanisms and on the lived experiences of people facing this clustering of adverse conditions. Unfortunately, our review only identified 2 studies employing such mixed methodology. Future research would benefit from generating and analysing qualitative data to support and enrich their quantitative findings.

Finally, we identified 2 interventional studies with mixed results. As co-targeting interconnected syndemic conditions is supported by a meta-analysis ([Pantalone et al., 2020](#ref-Pantalone2020)), we believe that syndemic-based interventions hold promise for improving the health of marginalized populations. Nonetheless, the mixed results presented in our review probably reflect the current shallowness of our understanding of how syndemics operate in different populations across the globe. Therefore, we should strive to close this knowledge gap in order to improve the design of future interventions. However, we do not recommend researchers wait before designing and testing syndemic-based interventions as such interventions may also contribute to our understanding of diseases interactions. In this regard, we share the view of Stall et al. in their response to Tsai review ([Stall et al., 2015](#ref-Stall2015a)). Given the harms caused to marginalized populations by a syndemic, we also agree with them when they state that ‘[w]e cannot wait until the methodological question of interaction is settled to develop interventions to address these co-morbidities within high risk populations’. Nonetheless only two interventions were conducted since this commentary was written seven years ago and we have made little progress in our understanding of disease interaction. This indicates an urgent need to move the field forward, both towards the comprehension of disease interaction and towards intervention development and implementation.

## Subpopulations

Studying the health of MSM poses a challenge regarding the diversity of this population. While nearly half of the studies included in our sample studied a subpopulation of MSM, the number of MSM subpopulations is such that most MSM subpopulation remains under-served. For example, Young Black MSM are specifically studied in 2 studies while representing 52% of the new HIV diagnosis among MSM aged 13-24 years in 2018 ([Center for Disease Control and Prevention, 2020](#X4cf13d81533c7b267d16e8ce422f52a6b94e857)).

This discrepancy between the number of studies focusing on a subpopulation and the very high prevalence of some syndemic condition such as HIV infection is even more concerning when considering that dual-minority identity may expose a person to different stressors and outcomes. For example, some studies found that Black MSM had a higher rate of HIV seroconversion than White MSM while being exposed to fewer syndemic conditions ([Mustanski et al., 2017](#ref-Mustanski2017)). These findings are supported by qualitative data suggesting that intersectional theory offers the context needed to understand syndemics among Black MSM which differ from syndemics among White MSM ([Quinn, 2019](#ref-Quinn)). Furthermore, the findings from Bulled suggest that structural disadvantage may have more weight on the lives of Black MSM than individual factors such as substance use ([Bulled, 2021](#ref-bulled2021)). We agree with the views of these authors and think that more attention should be given to structural disadvantages such as institutionalised racism and how it impacts the emergence of different syndemic conditions than in White MSM.

MSMW are another example of an under-served population with conflicting results. In a cross-sectional study using syndemic sum count, Latino MSMW with two or more syndemic conditions had a 7.09 Odds Ratio to engage in receptive condomless anal sex but no statistically significant difference was found for insertive condomless anal sex or condomless vaginal sex ([Muñoz-Laboy et al., 2018](#ref-Munoz-Laboy2018)). On the other hand, in another study the number of syndemic conditions was associated with HIV diagnosis for MSM but not for MSW or MSMW ([Bränström and Pachankis, 2018](#ref-Branstrom2018)). Among young MSM and MSMW, one study found more syndemic conditions and a greater association between them for MSMW compared to MSM ([Mustanski et al., 2014](#ref-Mustanski2014)). On the contrary, Ferlatte et al. found that MSM were more likely than MSMW to suffer from two or more syndemic conditions ([Ferlatte et al., 2018b](#ref-ferlatte2018)). These conflicting findings may be partly due to the difficulty to define and operate bisexuality in research ([Swan, 2018](#ref-swan2018)), differences between age groups or differences in syndemic mechanism for MSMW compared to MSM. Outside the field of syndemic literature, studies suggest that bisexual men suffer from a similar or higher burden of mental health conditions compared to gay men ([Chaudhry and Reisner, 2019](#ref-Chaudhry2019); [Ross et al., 2018](#ref-ross2018); [Salway et al., 2019](#ref-salway2019)) and literature specific to bisexual men remains scarce. In the future, syndemic theory should thus seek to study the specificity of this population. First, there is a need to better conceptualize and define bisexuality in the field - should we still use solely a behavior-based definition (as in MSMW) or should we incorporate a self-definition of one’s sexual orientation? Then, researchers should aim to disaggregate data concerning MSMW/bisexual men from data concerning MSM/gay men whenever possible. Lastly, more research focusing on MSMW/bisexual men is needed.

Finally transgender MSM were included in only one study in our sample. As stated in our results, this is concerning, especially when every other study excludes transgender men by design. As such, this population of MSM is the one we know the least about. It is striking that we had to exclude more studies merging transgender women and MSM than we have found studies focusing on transgender men. This conflation of sex and gender have already been decried ([Poteat et al., 2016](#ref-poteat2016)) and have contributed to our decision to exclude studies that reproduced this unfortunate practice. Linking transgender women and MSM on the assumption of shared biology and practices reduces transgender women to their birth assignation rather than their social identities. Conversely, excluding transgender MSM although they seem exposed to similar risk patterns as cisgender MSM ([Reisner et al., 2016](#ref-Reisner2016a)) because of their biological sex is, at best, revealing of a lack of knowledge about this population. Indeed, it seems counterproductive to give such precedence on the biological sex of participants over their social identifies while using a framework that considers diseases as socially caused. We believe that this practice is due to cissexist bias that should be avoided in future research.  
The health of transgender men remains greatly understudied and the few available studies suggest high rates of adverse conditions such as violence, notably sexual violence ([Testa et al., 2012](#ref-Testa2012)), suicide attempts ([Haas et al., 2014](#ref-Haas2014)), chlamydial and gonoccocal infections ([Pitasi et al., 2019](#ref-Pitasi2019)), intimate partner violence ([Peitzmeier et al., 2020](#ref-peitzmeier2020)) and HIV infection ([Becasen et al., 2019](#ref-Becasen2019)). Syndemic theory represents a promising framework for research on transgender men as its premises of social adversities producing and concentrating diseases in a population allows us to explore the health of transgender men without pathologising them.

## Syndemic conditions

There is a lack of consensus in the choice of syndemic conditions and the way they should be measured. We identified 46 different conditions in our quantitative sample, 9 of them were only studied once. Despite this diversity of syndemic conditions, the impact of the seminal study by Stall et al. ([Stall et al., 2003](#ref-Stall2003)) is striking. The conditions studied in that paper (depression, IPV, CSA and polysubstance use) are among the five most studied conditions in the field. Furthermore, 92% of the quantitative studies included in our review consider at least one of the four conditions studied by Stall and colleagues as part of a syndemic.

Some of these conditions are past events (e.g. history of trauma or childhood sexual abuse) while most were current conditions. Given the cross-sectional nature of 75% of the quantitative papers, we cannot disentangle how past experiences may influence the emergence of a syndemic.

Furthermore, studies diverge on what represents a syndemic condition and what may lead to the emergence of a syndemic. For example, childhood sexual abuse is mostly seen as a syndemic condition per se but may very well be a risk factor to the emergence of a syndemic, as hypothesized by some authors ([Herrick et al., 2013](#ref-Herrick2013); [Leblanc et al., 2021](#ref-leblanc2021)). The same question may be asked for other conditions, including discrimination, trauma, impulsivity, bullying, poor social support, loneliness, childhood abuse, or poor access to healthcare.  
Qualitative studies may help to distinguish between syndemic conditions and pathways to the emergence of a syndemic by drawing insight from the narratives of MSM. Life-story interviews, for example, offers the opportunity to explore the how early challenges shaped the narratives and lives of individuals. Adam et al. conducted one such investigation and found one major pathway of syndemic production characterized by childhood adversity leading to depression, substance abuse and risk-taking ([Adam et al., 2018](#ref-adam2018)). Two minor pathways characterised by migration stress or transition stress from home to college/work were also described. These findings are in line with Stall’s theory of syndemic production in which early socially-produced harms beginning in childhood continues through adolescence and adult life and is aggravated by the stresses associated with migration to large urban centres ([Stall et al., 2007](#ref-stall2007)). Given that the childhood damages are socially produced, the experiences that produce a syndemic may differ across generations or subpopulations of MSM ([Stall et al., 2007](#ref-stall2007)). As such, it may be possible that one condition, such as poor social support, participates in the emergence of a syndemic in a subpopulation of MSM while being part of a syndemic in another. As this theory is first and foremost a developmental theory of syndemic production, longitudinal studies may also help to disentangle pathways and syndemic conditions by surveying participants over an extended period of time. However, conflating the two in cross-sectional studies does very little to advance our understanding of syndemic theory or to implement public health interventions.

Furthermore, even when the same condition was studied in multiple papers, the differences in measurement methods impedes the reproducibility of the results. For example, let’s imagine a survivor of sexual intimate partner violence with a CESD score of 16, who uses marijuana on a regular basis and cocaine occasionally. This man would have been classified as depressed in 46% of studies using the CESD, a polysubstance user in 26% of studies considering polysubstance use and as a survivor of intimate partner violence in 49% of studies considering IPV. In other words, the same person could have been classified as having zero, one, two or even three syndemic conditions, depending on the study design. Considering that most studies use a summation score of the number of syndemic conditions to conduct regression analysis, it seems evident that the results would vary greatly according to the way the syndemic conditions are measured.

It is beyond the scope of this paper to provide an exhaustive list of syndemic conditions researchers should use from now on or to determine the best scale or set of criteria to use to measure these conditions. An absolute answer to these questions is likely unrealistic because of variations across subpopulations and geographical settings.  
However, we advise researchers to give more prominence to the local context and the lived experience of the population they seek to study when selecting syndemic conditions to investigate. Focus groups or Delphi survey interrogating peer navigators of grassroots organization serving MSM may help to select more pertinent variables. Indeed, by drawing into their own experiences and into their knowledge of the public with whom they work on daily, peer navigators may help researcher to ground their research.  
Additionally, exploratory qualitative studies may also serve as a first step in describing a syndemic arrangement before selecting syndemic conditions for a quantitative study. As Singer et al stated in their 2020 paper: ‘[t]he syndemic relationship first needs to be observed then measured, not theorised and used to predict diseases outcomes […]’ ([Singer et al., 2020](#ref-Singer2020)).

## Outcomes

Taken together, 97% of the quantitative studies in our sample had an HIV-related outcome, whether in the form of sexual risk behaviors, HIV diagnosis, HIV screening, adherence to antiretroviral therapy, PrEP use, viral load or engagement in HIV care.

This omnipresence of HIV in syndemic literature applied to MSM is understandable. The first description of a syndemic, the SAVA syndemic, incorporated AIDS as part of a syndemic ([Singer, 1996](#ref-singer1996)). Then, a few years later, the first paper on syndemic in the MSM population had HIV-related outcomes, in the form of HIV serostatus and CAS ([Stall et al., 2003](#ref-Stall2003)). Furthermore, MSM were the first and most severely affected population when the AIDS epidemic started ([De Cock et al., 2012](#ref-decock2012)). Nowadays, male-to-male sexual contact still represents nearly 70% of the new HIV cases in the USA ([Center for Disease Control and Prevention, 2020](#X4cf13d81533c7b267d16e8ce422f52a6b94e857)). While we can’t deny the importance of the HIV pandemic, notably for MSM, and especially in the Global South, were more research on syndemics and HIV are needed, we would argue that HIV is not the only issue in need of attention.

Indeed, MSM are also disproportionately affected by, amongst others, suicide, anxiety, depression and substance use ([Luo et al., 2017](#ref-luo2017); [Medley et al., 2016](#ref-Medley2016); [Ross et al., 2018](#ref-ross2018)). Moreover, with the advances in antiretroviral therapy and the subsequent decline in HIV-related mortality, a Canadian study showed that gay men were more likely to die from suicide than from HIV in 2011 ([Hottes et al., 2015](#ref-hottes2015)). Even if the estimates described in Hottes’ paper overestimate the mortality due to suicide among MSM, suicide would still be a leading cause of death in this population while being studied as an outcome in only 3 papers in our sample.

Furthermore, when studying HIV as an outcome, we would argue that using condomless anal sex as a proxy should be reviewed, and better proxies sought. Indeed, condomless anal sex was one of the criteria in 57 studies out of the 60 with sexual risk behaviors as an outcome and 32 studies considered all forms of condomless anal sex as a risk behavior. However, without refinement, this outcome fails to capture the changes in HIV prevention strategies such as PrEP or Treatment as Prevention (TasP). Only 3 studies in our sample took PrEP use and/or an undetectable viral load into account when considering condomless anal sex as a risk factor for HIV acquisition. Moreover, the earliest of this paper was published in 2019 ([Batchelder et al., 2019](#ref-Batchelder2019)) although the FDA have approved PrEP for HIV prevention in 2012.  
When the first paper on syndemic theory applied to MSM was published, engaging in condomless anal sex would have led to a high risk of acquiring HIV. Nowadays, people could be on PrEP, forego the use of a condom and still be at a very low risk of acquiring HIV ([Calabrese et al., 2017](#ref-calabrese2017)). Our methodologies in syndemic research should reflect this evolution. In addition, qualitative research gives an insight into risk behaviors and offers a more nuanced view on this topic than a binary variable of consistent condom use for anal intercourse. One such paper published in 2017 showed that risk practices fell into different subjectivities such as active and consistent pursuit of condomless sex, lack of assertiveness to a partner’s initiative of condomless anal sex and combination of episodic risk practices and reduction strategies ([Adam et al., 2017](#ref-Adam2017)). Besides, some studies showed that participants with a greater number of syndemic conditions would engage more frequently in condomless anal sex while not being more likely to test positive for HIV ([Mustanski et al., 2017](#ref-Mustanski2017); [Pitpitan et al., 2016](#ref-Pitpitan2016)). On the other hand, a paper from 2018 found that having a greater number of syndemic conditions was associated to self-reported HIV but not to condomless anal sex ([Chuang et al., 2018](#ref-chuang2018)). Taken together, we thus postulate that condomless anal sex should at least be replaced by “condomless anal sex without consistent PrEP use or with a detectable viral load” when an investigator seeks to use sexual risk behaviors as an outcome.

## Statistics and interaction

One of the tenets of syndemic theory is that there exists some form of biological, social and/or psychological interaction between the diseases ([Mendenhall and Singer, 2020](#ref-mendenhall2020)). As others have already pointed out, the extent to which syndemic literature had proved this core principle remains very limited ([Tsai and Burns, 2015](#ref-tsai2015)). Indeed, 45% of our quantitative sample of studies used solely a summation score of the syndemic conditions to conduct regression analysis. Two issues arise from this statistical approach. First, summation scores are additive by essence, thus unsuitable to demonstrate an interaction ([Tsai and Burns, 2015](#ref-tsai2015)). Second, two psychometric assumptions are made by such a model: (1) the unidimensionality of the construct and (2) equal factor weighting ([Halkitis et al., 2013](#ref-Halkitis2013a)). Put simply, using a summation score would imply that (1) every condition forms a single construct and that (2) every condition contributes equally to said construct (which would mean for example that feeling depressed during the past 14 days and having a history of childhood sexual abuse would contribute equally to a syndemic). The unidimensionality aspect of the construct has received some empirical support by Mustanski et al. as well as by Starks et al. using respectively Structural Equation Modeling and Latent Class Analysis ([Mustanski et al., 2014](#ref-Mustanski2014); [Starks et al., 2014](#ref-Starks2014)). On the contrary, Leblanc et al. failed to construct a single latent syndemic variable in their analysis ([Leblanc et al., 2021](#ref-leblanc2021)). Moreover, constraining factor loadings to be equal resulted in worse fit in the studies by Mustanski and Starks.

In short, the result of our review suggests that as much as 45% of the quantitative literature on syndemic theory applied to MSM doesn’t empirically support the presence of a syndemic and employs questionable statistical assumptions. Those studies are more an exploration of psychosocial risk factors associated to HIV acquisition or progression than the holistic framework syndemic is supposed to be.

As mentioned in the results, two statistically distinct models may be envisioned apart from synergistically interacting epidemics: mutually causal epidemics and serially causal epidemics ([Tsai, 2018](#ref-Tsai2018a)). As such, mediation analysis, path analysis or structural equation modeling may prove useful to assess an interaction.

More recently, a new statistical approach inspired from research in psychopathology has been used to model syndemics: network analysis ([Jasper S. Lee et al., 2020](#ref-Lee); [J. S. Lee et al., 2020](#ref-lee2020)). The core principle of this approach is that mental disorders arise from causal interactions between symptoms in a network ([Borsboom, 2017](#ref-borsboom2017)). Applied to syndemic theory, a syndemic would then be the network and the various conditions would then be the nodes of the network. Furthermore, one of the benefits of this approach resides in the theoretical possibility to identify influential nodes in a network: nodes that play a significant part in the activation of the network and that could be the prime target of an intervention in order to deactivate the network ([Robinaugh et al., 2016](#ref-robinaugh2016)). In short, in addition to being statistically sound and coherent with the model of mutually causal epidemics, network analysis could offer actionable data to improve the health of MSM by identifying which conditions should be prioritized for interventions ([Tsai, 2018](#ref-Tsai2018a)).

We recommend that future research should abandon the summation score approach and attempt to clarify which model of interaction receives the most empirical support in order to implement effective public health interventions. Indeed, as reminded by Chakrapani et al. the three models have different programmatic implications ([Chakrapani et al., 2019b](#ref-Chakrapani2019)). In the case of synergistically interacting epidemics, a single intervention may yield greater health improvement than if no interaction was present. For mutually causal epidemics, multicomponent interventions addressing the various epidemics should be implemented in order to produce an improvement. Finally, for serially causal epidemics, intervening at the root cause of a syndemic may prevent the development of a syndemic cascade.

## Additional frameworks

Resilience theory was the most frequently used framework to compliment syndemic theory.

Social support was shown to moderate the effect of syndemic conditions on viral load, providing a significant protective effect ([Friedman et al., 2016](#ref-friedman2016)). Moreover, a paper using Latent Transition Analysis to evaluate the impact of syndemic conditions on substance use showed that Black MSM with more social support were more likely to stay in the low-risk class or transitioning from the high-risk class to the low-risk class ([Turpin et al., 2020](#ref-turpin2020)). However, Chakrapani et al. found no moderation of social support on the relationship between syndemic conditions and risk taking ([Chakrapani et al., 2017](#ref-Chakrapani2017)).

On the topic of resilience resources, Zhang et al did not find evidence of a moderating effect of resilience on the relationship between syndemic conditions and physical activity ([Zhang et al., 2019](#ref-Zhang2019)). O’Leary et al. did not find a buffering effect of resilience factors on the relationship between syndemic conditions and sexual risk behaviors, though optimism and education buffered the relationship between syndemic conditions and self-reported HIV status ([O’Leary et al., 2014](#ref-OLeary2014a)). On the other hand, Kurtz et al found that, among MSM living with HIV, serosorting was positively associated with higher levels of two resilience factors: coping self-efficacy and positive coping skills ([Kurtz et al., 2012](#ref-Kurtz2012)). Similarly, Hart et al. found that psychosocial strengths were associated with lower likelihood of engaging in condomless anal sex, despite the presence of syndemic conditions ([Hart et al., 2017](#ref-Hart2017)).

In qualitative studies, resilience was also found to exert a protective effect against syndemic conditions ([Adam et al., 2018](#ref-adam2018); [Chakrapani et al., 2019a](#ref-Chakrapani2019a); [Reed and Miller, 2016](#ref-Reed2016)). Furthermore, the review by Woodwards et al. found a protective effect of most resilience resources identified against HIV ([Woodward et al., 2017](#ref-woodward2017)). Additionally, as pointed out by Namer and Razum, focusing on risk rather than resilience and survivorship poses the threat of alienating minority groups rather than prioritizing them ([Namer and Razum, 2021](#ref-namer2021)).

Minority stress represents another important framework as it explains how social stigma can get under the skin of minorized populations ([Meyer, 2003](#ref-Meyer2003)). Indeed, the minority stress is fully integrated in theories of syndemic production among MSM ([Singer et al., 2017](#ref-singer2017); [Stall et al., 2007](#ref-stall2007)). In these theories, the minority stress experienced by MSM leads do maladaptive coping strategies such as substance abuse, development of psychopathological conditions such as anxiety disorders and depression, hereby increasing sexual risk behaviors. Therefore, minority stress theory offers a mechanistic explanation of the second tenet of syndemic theory: the formation and clustering of diseases due to adverse social conditions.  
Moreover, as we recommend future research further incorporating mental health issues, minority stress theory should be more often integrated into future analysis.  
Additionally, we argue that another advantage of minority stress theory is that it avoids the pathologising of MSM by placing the focus on the social roots of mental health issues.

Finally, although intersectionality was only used by two studies ([Ferlatte et al., 2018b](#ref-ferlatte2018); [Quinn, 2019](#ref-Quinn)), we believe the field would benefit from this framework. Indeed, as shown in our results, there is some discrepancy in the results for MSM’s subpopulations, especially for MSMW/bisexual men, Black MSM and Latino MSM. We believe that the inattention to systemic inequalities and structural disadvantage in the field may partly explain these discrepancies. In fact, only 16% of the quantitative studies examine a structural condition such as discrimination, poverty or access to healthcare. However, as reminded by Bulled et al. one of the goals of the syndemic framework is to ‘identify the role of power and structural injustices in creating pathology and recognizing how pathology can intensify inequalities and multiple forms of oppression’ ([Bulled et al., 2022](#ref-bulled2022)).

Some scholars are skeptical of the usefulness of syndemic theory to intersectionality and question the possibility of a conversation between the two fields ([Sangaramoorthy and Benton, 2021](#ref-sangaramoorthy2021)). As pertinent as the authors commentary is, we do believe in the possibility of bringing the two fields together. As Quinn pointed out in her response, incorporating an intersectional framework into syndemic research may address issues of power, oppression and structural violence, neglected thus far in the field ([Quinn, 2021](#ref-quinn2021)). Doing so, we may address some gaps in the literature and disentangle the complex web of stigma and structural violence faced by sexual minority men, especially MSM situated at the intersection of multiple form of systemic discrimination such as racism, homophobia, biphobia, transphobia, classism, ableism or stigma against sex workers or people living with HIV. Furthermore, we agree with Bulled et al. when they argue that we need a syndemic analysis to understand clustering of diseases in marginalized populations ([Bulled et al., 2022](#ref-bulled2022)) . Moreover, given the results of this review, we share the opinion that most of the criticism from Sangaramoorthy and Benton stems from flaws in the way research in the field was conducted rather than flaws in the framework itself.

## Recommendations

In light of these results, we propose the following suggestions to improve the quality of research on syndemic theory applied to MSM:

1. The local context should be taken more seriously by scholars. Analysis of the physical space through spatial epidemiology should be encouraged while merging data from different states and countries should be avoided as it blurs our understanding of the socioeconomic and cultural contexts in which MSM evolve.
2. More research should be conducted in the Global South while considering the difficulties of transposing some measures in different sociocultural contexts.
3. Researchers should pay more attention to the selection of syndemic conditions to avoid unnecessary dispersion and to select the most relevant variables to MSM in a given place at a given time. Exploratory qualitative research and/or focus groups/Delphi survey should be used before trying to quantify a syndemic.
4. More attention should be paid to the selection of scales or sets of criteria when attempting to measure a syndemic condition to improve the reproducibility of the results.
5. A better understanding of how diseases interact is urgently needed. First, future research should abandon the summation score approach and aim to determine the model of interaction with the most empirical support. Second, future research should elucidate the mechanisms of bio-social and bio-bio interactions. Qualitative and mixed method studies should be employed more often to this end.
6. More attention should be given to structural disadvantage and systemic inequalities such as racism, biphobia, and transphobia. It is of paramount importance to gain a better insight into racial disparities in syndemic production. Moreover, the impact of monosexism and cissexism on the health of MSM should become a topic of investigation.
7. Transgender men should be included as any other MSM in future studies, rather than conflating sex and gender by excluding them while oftentimes including transgender women alongside MSM. Moreover, whenever possible, data from MSMW should be disaggregated to allow proper analysis.
8. Researchers should seek to study other aspect of MSM’s health than HIV infection. Mental health should not be neglected anymore. Moreover, when studying HIV infection, the outcome condomless anal sex should be replaced or refined.
9. Future work should continue to explore the impact of resilience in partially counteracting syndemics to develop public health interventions that aim to foster resilience resources among MSM.

# Strengths and limitations

This review is the first scoping review to map the current knowledge in syndemic theory applied to MSM. We charted and presented detailed data regarding the extant literature. As such, we offer insight and actionable recommendations for the future of the field. Our search strategy of electronic databases was comprehensive and developed with the help of the director of health sciences library of our institution. We combined this database search with a subsequent hand-search of references lists of the included studies. Moreover, we conducted a fully transparent and reproducible review. Other researchers may freely reuse our data and scripts to conduct their own work or use our online visualizations to identify papers pertinent for their research projects.

Nevertheless, though we took several steps to ensure the comprehensiveness of our search strategy, we may still have missed some relevant literature. Furthermore, one of our inclusion criteria was the centrality of syndemic theory to the screened paper. Although two reviewers screened a part of the studies independently, this criterion may be somewhat arbitrary and other researchers may have chosen to include papers we rejected or the contrary. Finally, the usual limitations of a scoping review apply such as the lack of risk of bias and strength of evidence assessment.

# Conclusion

Despite our critical stance on the current literature, we remain convinced that syndemic theory is a useful framework to study the health of marginalized populations in a holistic way and the current research still offers valuable insights on the health of MSM. It is vital that research continues to evolve in order to deepen our understanding and, by consequence, improve the health of marginalized populations worldwide.

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# Supplementary Materials

## A. PRISMA-ScR checklist

| **Section** | **Item** | **PRISMA-ScR checklist item** | **Reported on page #** |
| --- | --- | --- | --- |
| Title | 1 | Identify the report as a scoping review. | 1 |
| Abstract | 2 | Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives. | 1 |
| Rationale | 3 | Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach. | 2 |
| Objectives | 4 | Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives. | 2 |
| Protocol and registration | 5 | Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number. | 2 |
| Eligibility criteria | 6 | Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale. | 3 |
| Information sources | 7 | Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed. | 3 |
| Search | 8 | Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated. | 3 |
| Selection of sources of evidence | 9 | State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review. | 3 |
| Data charting process | 10 | Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators. | 3 |
| Data items | 11 | List and define all variables for which data were sought and any assumptions and simplifications made. | 3 |
| Critical appraisal of individual sources of evidence | 12 | If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate). | NA |
| Synthesis of results | 13 | Describe the methods of handling and summarizing the data that were charted. | 3-4 |
| Selection of sources of evidence | 14 | Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram. | 4-5 |
| Characteristics of sources of evidence | 15 | For each source of evidence, present characteristics for which data were charted and provide the citations. | 5-16 |
| Critical appraisal within sources of evidence | 16 | If done, present data on critical appraisal of included sources of evidence (see item 12). | NA |
| Results of individual sources of evidence | 17 | For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives. | Supplementary Materials, part B |
| Synthesis of results | 18 | Summarize and/or present the charting results as they relate to the review questions and objectives. | 16-21 |
| Summary of evidence | 19 | Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups. | 16-21 |
| Limitations | 20 | Discuss the limitations of the scoping review process. | 21 |
| Conclusions | 21 | Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps. | 21 |
| Funding | 22 | Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review. | 21 |

**Table 9.1:** Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

## B. Reference tables

| **References** | **Location** | **Design** | **Subpopulation** | **Syndemic conditions studied** | **Outcomes** | **Statistics used to model interaction** | **Key findings** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Achterbergh et al. 2021** | Netherlands | Randomized controlled trials (during 12 months intervention group (N=76) received tailored feedback and help-seeking advice on mental health screening to increase help-seeking behaviors (primary endpoint) as well as reducing sexual risk behaviors and STI incidence (secondary endpoint) ; control group (N=79) consisted of participants that didn't received results of their mental health screening nor tailored feedback or help-seeking advice) |  | depression, IPV, sexual compulsivity, anxiety, AUD, discrimination, substance use disorder, ADHD, alexithymia | engaging in sexual risk behaviors, HIV diagnosis, STI diagnosis, help-seeking behaviors | regression analysis using a summation score | This syndemic-based intervention to enhance help-seeking among high-risk MSM failed to improve help-seeking behaviours, STI incidence and sexual risk. Nonetheless, the extremely high incidence of STI incidence and mental health-related problems call for other type of interventions. |
| **Batchelder et al. 2019** | USA | Cross-sectional | MSM with a history of childhood sexual abuse | depression, PTSD, anxiety, substance use disorder | engaging in sexual risk behaviors, healthcare use, STI diagnosis | regression analysis using a summation score, significant product term in regression | There is an additive relationship between the number of psychiatric diagnoses and ER visits as well as condomless anal sex. No relationship was found between psychiatric diagnoses and STD. No interaction was found. |
| **Beymer et al. 2016** | USA | Longitudinal (66 months) | Latino MSM | substance use, IPV, sexual risk behaviors, STI | HIV diagnosis | Cox proportional hazards models | In this sample of Latino MSM, predictors of HIV seroconversion included history of STI, condomless anal sex, Methamphetamine Use, Central American birthplace, experience of IPV and same ethnicity of last sexual partner. |
| **Biello et al. 2014** | Vietnam | Cross-sectional | MSM engaged in sex work | depression, substance use, CSA, AUD, violence | engaging in sexual risk behaviors | regression analysis using a summation score | Experiencing a higher number of syndemic condition was associated with greater odds of engaging in condomless anal sex in this sample of Vietnamese male sex workers who have sex with men. This relationship was mainly driven by childhood sexual abuse and alcohol use disorder |
| **Biello et al. 2016** | Latin America | Cross-sectional | MSM living with HIV | depression, IPV, suicidality, sexual compulsivity, CSA, AUD, chemsex | adherence to antiviral medication, healthcare use, linkage to HIV care | regression analysis using a summation score | Experimenting syndemic conditions was associated with less engagement in HIV-related care, uptake of ART and adherence to ART among this sample of HIV positive MSM living in Latin America |
| **Blashill et al. 2020** | USA | Cross-sectional | Latino MSM | depression, substance use, IPV, binge drinking, CSA, polysubstance use, incarceration, unstable housing, poverty | PrEP-related outcomes | regression analysis using a summation score | Structural barriers such as unstable housing represent greater obstacles to being aware of the existence of PrEP than psychosocial conditions. However, once PrEP has been initiated, psychosocial conditions like intimate partner violence account for a greater variance in PrEP adherence. |
| **Blondeel et al. 2021** | Portugal | Cross-sectional |  | sexual risk behaviors, chemsex, frequenting gay social venues | HIV diagnosis, STI diagnosis | cluster analysis | 6 clusters with diverse patterns of sexual risk taking and STI/HIV vulnerability were identified. Among these clusters, the one with the highest HIV prevalence was the oldest one, reported the most condomless anal sex and had sex the most frequently with transgender partners, women and sex workers. |
| **Brandstrom and Pachankis 2018** | Sweden | Population-based cohort study | disagregated data for Men who have Sex with Men and Women | depression, binge drinking, suicidality, violence | HIV diagnosis | regression analysis using a summation score, observed/expected ratio | Sexual minority men are more likely to be diagnosed with HIV and to suffer from psychosocial conditions. However, the clustering of syndemic conditions and HIV was only found for gay men, not bisexual men |
| **Bulled et al. 2021** | USA | Cross-sectional |  | substance use, IPV, CSA, HIV |  | Relative Excess Risk due to Interaction (RERI), synergy factor analysis | Employing synergy factor analysis on the data set from Stall et al. this studies demonstrated a synergy among substance use, violence and HIV among white MSM in the sample. No synergy was found for other racial group |
| **Buttram et al. 2015** | USA | Mixed Quantitative cross-sectionnal and qualitative analysis with grounded theory | Black MSM | substance use disorder, violence, general mental distress |  | no interaction studied | Compared to White MSM, Black MSM experienced a wide range of disparities such as substance use, substance use disorder, exchange sex, unstable housing, unemployment, low educational attainment, arrest history, low social support and low satisfaction with one's living situation |
| **Byg et al. 2016** | USA | Cross-sectional | MSM living with HIV | depression, IPV, substance use disorder | glycemic control | multivariate linear regression | Poorer glycemic control was associated with a detectable viral load, high triglycerides and substance use |
| **Card et al. 2018** | Canada | Cross-sectional |  | depression, polysubstance use | engaging in sexual risk behaviors | moderation analysis, mediation analysis | AUDIT scores were not associated with risky sexual behaviors. The association between polysubstance use and depression was associated with greater odds of serodiscordant condomless anal sex. 18,2% of the effect of depression on serodiscordant CAS was mediated by polysubstance use. |
| **Carrico et al. 2018** | USA | Intact group design |  | depression, CSA, substance use disorder, sleep disturbance, childhood abuse | dysregulation of the hypoathalamic-pituitary-adrenal axis | moderation analysis | In meth-using MSM living with HIV, there is a disaggregation of the functional relationship between ACTH and cortisol, compared to HIV-negative, non-meth-using men |
| **Chakrapani et al. 2017** | India | Cross-sectional |  | depression, alcohol use, violence | engaging in sexual risk behaviors | regression analysis using a summation score | In this sample of Indian MSM, there was a positive relationship between the number of syndemic conditions and sexual risk taking. This relationship was moderated by resilient coping but not by social support. |
| **Chakrapani et al. 2019b** | India | Cross-sectional |  | substance use, alcohol use, violence | engaging in sexual risk behaviors | Relative Excess Risk due to Interaction (RERI), significant product term in regression, mediation analysis, path analysis | In this population-based study of Indian MSM, the authors found empiric support to three models of interacting epidemics : synergistically interacting epidemics, serially causal epidemics and mutually causal epidemics, with the strongest support for the model of synergistically interacting epidemics |
| **Chakrapani et al. 2020** | India | Pretest-posttest nonequivalent groups (during 12 months intervention group (N=229) received a Motivational Interview-based HIV prevention intervention to reduce condomless anal intercourse by improving condom self-efficacy and by addressing co-occurring psychosocial conditions ; control group (N=230) consisted of MSM receiving standard of care in another NGO) |  | depression, AUD, internalised homophobia | engaging in sexual risk behaviors | Relative Excess Risk due to Interaction (RERI), significant product term in regression, mediation analysis | This motivational interview-based intervention guided by syndemic theory was effective in improving consistent condom use and in reducing the three psychosocial conditions investigated (depression, alcohol use and internalised homophobia). Synergy was present for depression and alcool use and for depression and internalised homophobia on inconsistent condom use. Mediation analysis revealed that the intervention led to a reduction in alcool use and internalised homophobia which improved condom self-efficacy which ultimately led to an improvement in consistent condom use |
| **Chandler et al. 2020a** | USA | Cross-sectional | Black MSM | depression, IPV, binge drinking, polysubstance use | PrEP-related outcomes | regression analysis using a summation score, Relative Excess Risk due to Interaction (RERI) | BMSM on PrEP were most likely to suffer from IPV, engage in problematic binge drinking and polysubstance use. Synergy was found between all the syndemic conditions |
| **Chandler et al. 2020b** | USA | Cross-sectional | Black MSM | depression, IPV, binge drinking, polysubstance use, sexual risk behaviors | HIV\_screening | regression analysis using a summation score, Relative Excess Risk due to Interaction (RERI) | The men most at risk were more likely to test, such as the syndemic variables did not adequately explain discrepancy in HIV screening among BMSM. Synergy in preventing HIV screening was present between poly drug use, depression and binge drinking as well as between binge drinking, depression and sexual risk behaviors. |
| **Chandler et al. 2020c** | USA | Cross-sectional | Black MSM engaged in sex work | depression, IPV, polysubstance use, violence | STI diagnosis | mediation analysis, Structural Equation Modeling | In this sample of BMSM engaged in sex work, there were a direct relationship between syndemic conditions and engagement in sex work as well as between engagement in sex work and past-year STI diagnosis. Furthermore, syndemic conditions were found to partially mediate the relationship between engagement in sex work and past-year STI, accounting for 64,2% of this relationship. |
| **Chuang et al. 2018** | Taiwan | Cross-sectional |  | IPV, discrimination, substance use disorder | engaging in sexual risk behaviors, HIV diagnosis | regression analysis using a summation score | Experiencing a greater number of syndemic conditions was associated with higher odds of self-reported postive HIV status but not with condomless anal sex nor number of partners |
| **Chuang et al. 2021** | Taiwan | Cross-sectional |  | substance use, IPV, CSA, internalised homophobia, childhood abuse | engaging in sexual risk behaviors, HIV diagnosis | regression analysis using a summation score, Relative Excess Risk due to Interaction (RERI) | Taiwanese MSM were burdened with a high level of syndemic conditions and people experienceing more syndemic conditions were more likely to engage in condomless anal sex or report a positive HIV status. Furthermore three 2-ways and two 3-ways interactive effects on HIV infection were identified |
| **Dyer et al. 2012** | USA | Cross-sectional | Black MSM | depression, substance use, IPV, binge drinking, sexual compulsivity, stress | engaging in sexual risk behaviors, syndemic conditions as the outcomes | regression analysis using a summation score | Gay-related and non-gay-related victimization in school, perception of failures in masculinity, social connectedness, internalized homophobia, discrimination and life satisfaction were associated with having 2 or more syndemic conditions. Furthermore, having 3 or more syndemic conditions was associated with condomless anal sex |
| **Dyer et al. 2020** | USA | Longitudinal (12 months) | Black MSM, disagregated data for Black Men who have Sex with Men and Women | depression, substance use, IPV, binge drinking, incarceration, discrimination, experience of trauma | STI diagnosis | Latent Class Analysis/Latent Profile Analysis, mediation analysis | Different syndemic profiles were found for BMSMO and BMSMW. Furthermore BMSMO had higher STI incidence compared to BMSMW and this difference in incidence was partly mediated by high risk sexual behaviors. |
| **Eaton et al. 2013** | South Africa | Cross-sectional | Men who have Sex with Men and Women | substance use, IPV, CSA, alcohol use, sexual risk behaviors, violence | having sex with both men and women | no interaction studied | In multivariate analysis, self-reported positive HIV status and childhood sexual abuse were associated with higher odds of reporting sex with both men and women. Furthermore recent interpartner violence, recent sexual violence and childhood sexual abuse were significantly inter-associated but were not associated with sexual risk or substance/alcohol use |
| **Ferlatte et al. 2014** | Canada | Cross-sectional |  | depression, substance use disorder, loneliness | engaging in sexual risk behaviors | regression analysis using a summation score | Experiencing multiple anti-gay experiences was associated with syndemic conditions : a greater number of syndemic conditions was then subsequently associated with greater odds of engaging in serodiscordant condomless anal sex |
| **Ferlatte et al. 2015** | Canada | Cross-sectional |  | depression, substance use, anxiety, tobacco use, sexual risk behaviors, STI, HIV | suicidality | regression analysis using a summation score | Syndemic theory is appropriate for studying suicide ideation and attempts among MSM. Notably, those reporting 3 syndemic conditions had 6.9 times the odds of suicide ideation and 16,29 times the odds of suicide attempts, mainly driven by anxiety and depression. |
| **Ferlatte et al. 2018a** | Canada | Cross-sectional |  | substance use, IPV, binge drinking, suicidality, general mental distress | STI diagnosis | regression analysis using a summation score, Relative Excess Risk due to Interaction (RERI) | Healthcare discrimination, a cumulative count of syndemic and a cumulative count of antigay stigma were associated with syphilis diagnosis in the past 12 months. The RERI for cumulative count of syndemic conditions was not significant. IPV and substance use were associated with syphilis, after adjusting for other syndemic conditions. |
| **Ferlatte et al. 2018b** | Canada | Cross-sectional | disagregated data for Men who have Sex with Men and Women | depression, substance use, binge drinking, suicidality, anxiety | engaging in sexual risk behaviors, syndemic conditions as the outcomes | regression analysis using a summation score | Gay men were more likely to experiment two or more syndemic conditions compared to bisexual men and female-partnered MSM. This difference was mainly driven by higher odds of consuming party drugs and being treated for anxiety/depression. Furthermore, being single, younger than 45 years old, of Indigenous ancestry, earning less than $60,000 per year and living in an urban environment were also associated with higher odds of experimenting two or more syndemic conditions |
| **Friedman et al. 2014** | USA | Cross-sectional | disagregated data for Men who have Sex with Men and Women | depression, sexual compulsivity, unstable housing, violence | engaging in exchange sex, engaging in sexual risk behaviors, engaging in chemsex | regression analysis using a summation score, hierarchical negative binomial regression | Among MSMW, syndemic conditions explained 31,1% of the variance in exchange sex but only 3.6% of the variance in chemsex. Exchange sex, in turn was associated with serodiscordant condomless anal sex while chemsex alone was not. Furthermore no direct association between syndemic conditions and serodiscodant condomless anal was found |
| **Friedman et al. 2015** | USA | Longitudinal (78 months) | MSM living with HIV | depression, polysubstance use, sexual risk behaviors | adherence to antiviral medication, viral load | regression analysis using a summation score, mediation analysis, Structural Equation Modeling | In this longitudinal study, the sum of syndemic conditions was associated with lower ART adherence and higher viral load among MSM living with HIV. Furthermore, the effect of syndemic conditions on viral load was partially mediated by ART adherence. |
| **Friedman et al. 2016** | USA | Longitudinal (72 months) | MSM living with HIV | depression, polysubstance use, sexual risk behaviors | adherence to antiviral medication, viral load | regression analysis using a summation score, moderation analysis | Among MSM living with HIV, functional social support moderates the effect of syndemic conditions on viral load suppression, providing a significant protective effect |
| **Guadamuz et al. 2014** | Thailand | Longitudinal (3.8 year) |  | substance use, suicidality, alcohol use, exchange sex, poor social support, violence | engaging in sexual risk behaviors, HIV diagnosis | regression analysis using a summation score | A higher number of syndemic conditions was significantly associated with greater odds of condomless anal sex, a higher HIV prevalence and a higher HIV incidence |
| **Halkitis et al. 2012** | USA | Mixed (cross-sectional quantitative method and discovery interview) | Older MSM living with HIV | depression, substance use, PTSD, alcohol use | engaging in sexual risk behaviors | regression analysis using a summation score | High prevalence of psychiatric conditions (PTSD and depression) as well as substance use among older MSM living with HIV. These psychosocial burdens are associated with unprotected anal intercourse. |
| **Halkitis et al. 2013** | USA | Cross-sectional | Young MSM | depression, substance use, PTSD, suicidality, alcohol use, sexual risk behaviors, loneliness |  | Structural Equation Modeling | A second-order model consisting of drug use and mental health burden was associated with a first-order model for unprotected sex, both indicated by numerous variables |
| **Halkitis et al. 2015** | USA | Longitudinal (36 months) | Young MSM | depression, substance use, PTSD, suicidality, alcohol use, sexual risk behaviors, loneliness |  | Confirmatory Factor Analysis | There was an increased use of substance and sexual risk behaviors with increasing age of this cohort of YMSM. Furthermore, the relative contribution of the syndemic indicator variables on the latent constructs varied accros time while still loading onto one latent construct across the four time points |
| **Harkness et al. 2018** | USA | Longitudinal (12 months) | MSM living with HIV | depression, substance use, PTSD, binge drinking, anxiety, CSA, polysubstance use | adherence to antiviral medication | regression analysis using a summation score | Participants' average syndemic score over the 12 months period predicted their non-adherence scores but not the time-specific changes in their average level. Furthermore, the effects of syndemic conditions on viral load may be mediated by non-adherence. |
| **Harkness et al. 2019** | USA | Longitudinal (12 months) | MSM living with HIV | depression, substance use, PTSD, binge drinking, anxiety, CSA, polysubstance use | engaging in sexual risk behaviors | regression analysis using a summation score | Syndemic score significantly predicted serodiscordant CAS and this effect was attributable to variation in score within person during the study as well as variation of mean score between participants |
| **Hart et al. 2017** | Canada | Longitudinal (6 months) |  | depression, CSA, polysubstance use, discrimination | engaging in sexual risk behaviors | regression analysis using a summation score | Psychosocial strengths were associated with a lesser odds of engagement in condomless anal sex, despite the presence of syndemic conditions. Psychosocial strenghts may operate in the same way as syndemic conditions but in an opposite direction. |
| **Herrick et al. 2013** | USA | Cross-sectional | MSM living with HIV | depression, substance use, IPV, sexual compulsivity, stress | syndemic conditions as the outcomes | hierarchical negative binomial regression | In this life-course approach of syndemic production among MSM, current forms of adversity (i.e. event discrimination, current marginalization and general life satisfaction) accounted for the largest contribution to the model while early life events also contributed significantly with childhood victimization and self-perception of failing masculinity attainment remaining significantly associated to the syndemic outcome variable after controlling for all other factors |
| **Herrick et al. 2014** | USA | Longitudinal (24 months) | Young MSM | depression, substance use, binge drinking | engaging in sexual risk behaviors | regression analysis using a summation score, mediation analysis | A greater number of syndemic conditions was associated with increased odds of sexual risk behaviors. Furthermore, experiences of adversity play an important role in syndemic formation and syndemic conditions mediate the pathway from adversity to sexual risk behaviors |
| **Hirshfield et al. 2015** | USA | Cross-sectional |  | depression, polysubstance use, incarceration, alcohol use | engaging in sexual risk behaviors | regression analysis using a summation score | MSM with encounters with 4 or more partners constitute a particularly high risk subgroup of MSM, with more condomless anal sex, polysubstance use, STI diagnosis and HIV prevalence. Furthermore, a higher count of syndemic conditions was associated with odds of participating in encounters with 4 or more partners. |
| **Hugh Klein 2011** | USA | Cross-sectional |  | depression, substance use, low self-esteem | engaging in sexual risk behaviors | Structural Equation Modeling | Emotional neglect in childhood and demographic factors influenced self-esteem which, in turn, along with substance use and several demographic and psychological functioning variables, influenced attitudes toward condom. This last variable predicted engagement in condomless anal and oral sex |
| **Jiang et al. 2020** | China | Cross-sectional |  | depression, IPV, CSA, chemsex | engaging in sexual risk behaviors, HIV diagnosis | regression analysis using a summation score, Relative Excess Risk due to Interaction (RERI), moderation analysis | Depression and use of rush popper before sexual intercourse interacted to increase the number of sexual partners. CSA and use of rush popper before sexual intercourse interacted to increase the risk of HIV infection. Neither education nor income moderated the effects of syndemic factors on sexual risks taking or HIV infection |
| **Jie et al. 2012** | China | Cross-sectional |  | depression, IPV, binge drinking, CSA, polysubstance use | engaging in sexual risk behaviors, HIV diagnosis | regression analysis using a summation score, mediation analysis | Experiencing a greater number of syndemic conditions was associated with sexual risk behaviors and HIV infection and the relationship between syndemic conditions and HIV infection seems to be partially mediated by sexual risk behaviors |
| **Kurtz et al. 2012** | USA | Cross-sectional | disagregated data for MSM living with HIV | substance use disorder, violence, cognitive escape, general mental distress | engaging in sexual risk behaviors | multivariate logistic regression | Serosorting among MSM living with HIV was positively associated with lower levels of cognitive escape and higher levels of two resilience factors : coping self-efficacy and positive coping skills. Among HIV-negative men, serosorting was positively associated with lower levels of cognitive escape, violence victimization and severe mental distress as well as with higher levels of coping self-efficacy and social engagements and with lower levels of negative coping skills |
| **Leblanc et al. 2021** | USA | Longitudinal (12 months) | Black MSM | depression, substance use, violence | engaging in exchange sex, engaging in sexual risk behaviors | Structural Equation Modeling | Ecological factors such as economic vulnerability and anti-Black or homophobic violence had an influence on situational sex (drug use during sex and exchange sex) via depression |
| **Lee et al. 2020a** | USA | Cross-sectional |  | depression, substance use, IPV, binge drinking, suicidality, sexual compulsivity, anxiety, IDU, CSA |  | Exploratory Factor Analysis, Network Analysis | Network analysis is a valuable methodology to examine patterns of synergistic relationships among psychosocial conditions that form a syndemic and may be preferable to EFA. Suicidal ideation, IDU, substance use and depression were the four most central nodes, suggesting that they may be important psychosocial syndemic indicators to investigate as well as targets of intervention |
| **Lee et al. 2020b** | USA | Cross-sectional | Latino MSM | depression, substance use, IPV, IDU, CSA, incarceration, unstable housing, poverty, alcohol use | engaging in sexual risk behaviors | Network Analysis | Network analysis is feasible for studying syndemics. CAS and alcohol use were significantly associated as well as CSA and alcohol use, non-injection substance use and IPV. The four most central nodes were unstable housing, incarceration, CSA and CAS |
| **Li et al. 2016** | China | Cross-sectional |  | depression, substance use, sexual compulsivity, anxiety, sexual risk behaviors, poor social support, loneliness, involuntary subordination, low self-esteem, impulsivity | suicidality | regression analysis using a summation score | A higher number of syndemic conditions was associated with greater suicidal ideation among MSM, especially when the number of syndemic conditions reaches five. Among these conditions, only involuntary subordination and sexual risk taking remained significant in multivariate analysis |
| **Martinez et al. 2016** | USA | Cross-sectional | Latino MSM | depression, binge drinking, CSA, discrimination | engaging in sexual risk behaviors | regression analysis using a summation score | 90% of this sample of Latino MSM reported at least one syndemic condition and having a greater number of syndemic conditions was associated with higher odds of CAS and multiple sexual partners |
| **Martinez et al. 2020** | USA | Cross-sectional | Latino MSM | binge drinking, exchange sex, discrimination | engaging in sexual risk behaviors | regression analysis using a summation score | Having 2 or more syndemic conditions increased the number of male partners and CAS with casual partners in this sample of Latinx MSM in Philadelphia |
| **McDaid et al. 2019** | International | Cross-sectional |  | depression, IPV, suicidality, anxiety, STI, poor physical health | syndemic conditions as the outcomes | observed/expected ratio | Syndemic indicators of poor physical, mental and sexual health cluster and are partly influenced by a pathogenic social context and salutogenic community assets |
| **Mimiaga et al. 2015a** | Latin America | Cross-sectional |  | depression, IPV, suicidality, sexual compulsivity, CSA, AUD, chemsex | engaging in sexual risk behaviors, HIV diagnosis | regression analysis using a summation score | he number of syndemic conditions was associated with higher odds of engaging in CAS and self-report of HIV diagnosis |
| **Mimiaga et al. 2015b** | USA | Longitudinal (48 months) |  | depression, substance use, binge drinking, CSA, polysubstance use | engaging in sexual risk behaviors, HIV diagnosis | regression analysis using a summation score, mediation analysis | In this longitudinal study, experiencing a greater number of syndemic conditions was associated with higher odds of HIV seroconversion over the 4-years follow-up and this effect was partially mediated by sexual risk behaviors |
| **Mimiaga et al. 2021** | USA | Longitudinal (12 months) | MSM engaged in sex work | depression, substance use, CSA, polysubstance use, AUD, violence | engaging in sexual risk behaviors | regression analysis using a summation score | This sample of male sex workers who have sex with men was burdened with a high prevalence of syndemic conditions. Furthermore, a higher count of syndemic condition was associated with higher odds of engaging in condomless anal sex |
| **Moeller et al. 2011** | USA | Cross-sectional |  | depression, substance use, anxiety, hostility | engaging in sexual risk behaviors | regression analysis using a summation score | A greater number of syndemic conditions was associated with condomless anal sex with both HIV-positive and HIV-negative partners but not with HIV status |
| **Morrison et al. 2018** | Canada | Cross-sectional |  | depression, sexual compulsivity, AUD, substance use disorder | engaging in sexual risk behaviors | regression analysis using a summation score, significant product term in regression | MSM seeking PEP in this sample were affected by a high burden of syndemic conditions. Furthermore, the number of syndemic conditions in an individual was associated with an increased HIV risk |
| **Muñoz-Laboy et al. 2018** | USA | Cross-sectional | Latino Men who have Sex with Men and Women | depression, CSA, polysubstance use | engaging in sexual risk behaviors, STI diagnosis | regression analysis using a summation score | Among this sample of LMSMW, having at least 2 syndemic conditions predicted lifetime STI and condomless receptive anal sex but not condomless insertive anal sex nor condomless vaginal sex |
| **Mustanski 2014** | USA | Cross-sectional | Young MSM, disagregated data for Men who have Sex with Men and Women | depression, substance use, IPV, binge drinking, sexual risk behaviors | suicidality | Structural Equation Modeling, Confirmatory Factor Analysis | Experiences of victimization and bullying increased the syndemic burden of all youths and subsequently syndemic burden increased suicide attempts. These findings held true for young men who have sex with women (YMSW), young men who have sex with men (YMSM) and young men who have sex with men and women (YMSMW). However, these relationships were much stronger among sexual minority youths and syndemic conditions clustered with particular strength among YMSMW |
| **Mustanski et al. 2007** | USA | Cross-sectional | Young MSM | substance use, IPV, binge drinking, violence, general mental distress | engaging in sexual risk behaviors, HIV diagnosis | regression analysis using a summation score | Experiencing a greater number of syndemic conditions was associated with higher odds of condomless anal sex, multiple sex partners and reported positive HIV status |
| **Mustanski et al. 2017** | USA | Longitudinal (12 months) | Young MSM, disagregated data for Black & Latino MSM | depression, IPV, binge drinking, suicidality, CSA, polysubstance use, AUD, discrimination | engaging in sexual risk behaviors, HIV diagnosis, STI diagnosis | Structural Equation Modeling | The study found evidence of a predictive ability of syndemic factors on sexual risk behaviors but there were no association with HIV/STI incidence. Furthermore, Black YMSM had both the highest seroconversion rate in the sample and a lesser burden in syndemic conditons compared to White and Latino YMSM, questioning the usefulness of syndemic theory on Black MSM or the need to take into account other syndemic conditions to explain the high rates of HIV acquisition among Black MSM |
| **Ng et al. 2020** | Malaysia | Cross-sectional | disagregated data for MSM living with HIV | depression, IPV, suicidality, CSA, chemsex | engaging in sexual risk behaviors, HIV diagnosis | regression analysis using a summation score | In this sample of Malaysian MSM, condomless anal sex was associated with depression and chemsex while self-reported HIV status was associated with depression, suicidal risk, chemsex and a history of CSA. Furthermore, self-reported HIV status was associated with the number of syndemic conditions |
| **Nostlinger et al. 2020** | Belgium | Longitudinal (18 months) |  | depression, substance use | engaging in sexual risk behaviors | regression analysis using a summation score, significant product term in regression | There was an interaction effet of recreational effect and drug use, potentiating sexual risk behaviors at baseline but not at 9 months or 18 months follow-up |
| **O'Leary et al. 2014** | USA | Cross-sectional | Black MSM | depression, IPV, CSA, AUD, substance use disorder | engaging in sexual risk behaviors, HIV diagnosis | regression analysis using a summation score | Experiencing a higher number of syndemic conditions was associated with greater odds of engaging in condomless anal sex and a higher prevalence of self-reported positive HIV status. Optimism and education buffered the relationship between syndemic conditions and self-reported HIV status but other resilience factors (connection to gay community, religiosity, Black pride and income) did not. Furthermore, none of the resilience factors buffered the relationship between syndemic conditions and sexual risk behaviors |
| **OCleirigh et al. 2018** | USA | Cross-sectional |  | substance use, IPV, suicidality, CSA | HIV diagnosis, healthcare use | regression analysis using a summation score | Experiencing syndemic conditions was associated with an increase in medical visits, medical costs and odds of self-reporting a positive HIV status |
| **Oginni et al. 2019** | Nigeria | Cross-sectional |  | depression, substance use, IPV, suicidality, alcohol use, tobacco use, childhood abuse | engaging in sexual risk behaviors | regression analysis using a summation score | Compared to straight men, MSM had greater odds of having experienced childhood adversity, IPV, depressive symptoms and suicidal thoughts. Furthermore experiencing a greater number of syndemic condition was associated with higher odds of engaging in sexual risk behaviors |
| **Ogunbajo et al. 2019** | Nigeria | Cross-sectional |  | depression, substance use, PTSD, AUD, tobacco use | engaging in sexual risk behaviors | regression analysis using a summation score | Association between PTSD and alcohol dependence as well as between alcohol dependence and hard drug use. The number of syndemic conditions was associated with a greater number of male partners but not with inconsistent condom use |
| **Pantalone et al. 2018** | USA | Cross-sectional | MSM living with HIV | IPV, suicidality, CSA, polysubstance use | adherence to antiviral medication, engaging in sexual risk behaviors, healthcare use | regression analysis using a summation score | In this sample of MSM living with HIV, the number of syndemic conditions was associated with ART adherence, having one syndemic condition was associated with inpatient medical admissions in the past year. Serodiscordant condomless anal sex was not associated with the syndemic count variable |
| **Parsons et al. 2012** | USA | Cross-sectional |  | depression, IPV, sexual compulsivity, CSA, polysubstance use | engaging in sexual risk behaviors, HIV diagnosis | regression analysis using a summation score | Sexual compulsivity was significantly associated with depression and IPV in multivariate analysis, as well as with self-reported positive HIV status and serodiscordant condomless anal sex. Furthermore, experiencing a greater number of syndemic conditions was associated with higher odds of engaging in sexual risk behaviors and reporting a positive HIV status |
| **Parsons et al. 2015** | USA | Cross-sectional |  | depression, IPV, sexual compulsivity, CSA, polysubstance use, hypersexuality | engaging in sexual risk behaviors, HIV diagnosis | regression analysis using a summation score, mediation analysis | In this sample of highly sexually active MSM, sexual compulsivity and hypersexuality seemed to act as a syndemic condition associated with an increase in HIV risk rather than as a mediator of syndemic conditions on HIV risk. Furthermore, these findings provide support for a three group conceptualization of hypersexuality and sexual compulsivity (one, both or none) |
| **Parsons et al. 2017** | USA | Cross-sectional |  | depression, IPV, sexual compulsivity, CSA, polysubstance use | engaging in sexual risk behaviors | regression analysis using a summation score | Among a U.S. national sample of MSM, the sum of syndemic conditions was associated with greater likelihood of reporting sexual risk behaviours. Furthermore, MSM living in non-urban areas were more likely to experience sexual compulsivity. |
| **Perry et al. 2019** | USA | Cross-sectional | Adolescent MSM | substance use, CSA, AUD, general mental distress | engaging in sexual risk behaviors | regression analysis using a summation score | Syndemic conditions emerge early in the lifespan and are associated with early sexual experiences. Internalizing symptoms, problematic alcohol use, CSA and marijuana use were highly prevalent and interrelated. |
| **Pitpitan et al. 2016** | Mexico | Cross-sectional |  | depression, substance use, sexual compulsivity, internalised homophobia, violence | engaging in sexual risk behaviors | regression analysis using a summation score, moderation analysis | The number of syndemic conditions was associated with higher odds of engaging in condomless anal sex with a stranger. This effect was more pronounced in MSM who are out to less than 50% of their acquaintances |
| **Quinn et al. 2020** | USA | Longitudinal (18 months) | Latino MSM | incarceration, unstable housing, unemployment, poor healthcare access | engaging in sexual risk behaviors, viral load | regression analysis using a summation score | Experiencing structural syndemic conditions was associated with more sexual risk behaviors, both from HIV-positive and HIV-negative participants as well as with a detectable viral load among HIV-positive participants |
| **Reisner et al. 2016** | USA | Cross-sectional | Transgender MSM | depression, IPV, binge drinking, anxiety, CSA, polysubstance use, childhood abuse | engaging in sexual risk behaviors, STI diagnosis | regression analysis using a summation score, moderation analysis | In this sample of transgender MSM, syndemic conditions were associated with higher odds of engaging in condomless vaginal and/or anal sex and this association was fully moderated by social gender affirmation, suggesting similar sexual risk patterns for TMSM who have socially afirmed their gender identity as for cisgender MSM |
| **Safren et al. 2018** | USA | Longitudinal (6 months) |  | depression, IPV, sexual compulsivity, anxiety, CSA, AUD, substance use disorder | engaging in sexual risk behaviors | regression analysis using a summation score, mediation analysis | Cross-sectional analysis showed an indirect effect of syndemic conditions on condomless sex through lowered condom self-efficacy. However, a full longitudinal model was not supported by the data as changes in condom self-efficacy was not associated with changes in condomless sex |
| **Santos et al. 2014** | International | Cross-sectional |  | depression, substance use, unstable housing, discrimination, poor healthcare access, violence | engaging in sexual risk behaviors, HIV diagnosis | regression analysis using a summation score | Experiencing a higher number of syndemic conditions was associated with higher odds of engaging in condomless anal sex and self-reported positive HIV status |
| **Satyanarayana et al. 2021** | USA | Longitudinal (10 years) | MSM living with HIV | depression, anxiety, AUD, substance use disorder | HIV transmission | regression analysis using a summation score | This study showed an effect of the number of syndemic conditions on HIV transmissions over and above time in care |
| **Scheer et al. 2021** | USA | Cross-sectional |  | suicidality, polysubstance use, AUD, HIV | engaging in sexual risk behaviors | Latent Class Analysis/Latent Profile Analysis | Four classes of syndemic conditions were identified and class membership was associated with HIV risk behaviors. Notably, the MSM concurrently engaging in polysubstance use and living with HIV engaged in more HIV risk behaviors while MSM presenting higher levels of alcohol misuses demonstrated reduced HIV risk behaviors. |
| **Semple et al. 2017** | Mexico | Cross-sectional |  | depression, substance use, PTSD, sexual compulsivity, CSA, AUD, discrimination, sexual risk behaviors, hostility | having experienced sexual violence | multivariate linear regression | There is a high reported frequency of sexual violence among MSM in Tijuana. Furthermore, the authors suggest a model of co-occurring psychosocial factors such as CSA, adult homophobia, depressive symptoms and hostility that increase the odds of sexual violence experiences among MSM |
| **Shuper et al. 2020** | Canada | Cross-sectional |  | depression, substance use, AUD | PrEP-related outcomes | regression analysis using a summation score, significant product term in regression | Problematic alcohol use and cocaine use were found to be additively associated with PrEP nonadherence but no synergy were found between these two conditions. Furthermore, depression was not shown to be associated with PrEP nonadherence in this sample |
| **Stall et al. 2003** | USA | Cross-sectional |  | depression, IPV, CSA, polysubstance use | engaging in sexual risk behaviors, HIV diagnosis | regression analysis using a summation score | A greater number of syndemic conditions was associated with positive HIV status and sexual risk behaviors |
| **Starks 2014** | USA | Cross-sectional |  | depression, IPV, sexual compulsivity, CSA, polysubstance use |  | Latent Class Analysis/Latent Profile Analysis, Confirmatory Factor Analysis | In this study, constraining factor loadings to be equal, as it is done with summary score of syndemic conditions, significantly reduced model fit. In the other hand, a latent class analysis produced two ordinal categories of low syndemic burden and high syndemic burden, which is consistent with an underlying unidimensional syndemic stress factor |
| **Starks et al. 2016** | USA | Cross-sectional |  | depression, IPV, sexual compulsivity, CSA, polysubstance use | engaging in sexual risk behaviors | regression analysis using a summation score | The sum of syndemic conditions experienced by the partners in a couple was associated with condomless sex during first sexual intercourse and with non-disclosure of HIV status prior to first condomless anal sex |
| **Storholm et al. 2011** | USA | Cross-sectional | Young MSM | substance use, alcohol use, tobacco use, sexual risk behaviors, chemsex |  | point-biserial correlation | YMSM who reported smoking cigarettes were more likely to use marijuana, cocaine, inhalant nitrates, ecstasy, methamphetamine, hallucinogens, Adderall/Ritalin without prescription and to use alcohol until intoxication. Furthermore, they were also more likely to ingage in sexual risk behaviors such as use of substance before or during sex |
| **Sullivan and Eaton 2020** | USA | Cross-sectional | Black MSM | depression, substance use, AUD, exchange sex | PrEP-related outcomes | regression analysis using a summation score | MSM with a lower socio-economical status were less likely to be aware of PrEP and experiencing multiple syndemic conditions was associated with reduced odds of using PrEP although, taken independently, these conditions were not associated with PrEP use |
| **Tan et al. 2016** | Canada | Case series |  | depression, AUD, substance use disorder |  | no interaction studied | A high burden of mental health problem was found in this sample of MSM PrEP Users. Using self-administered questionnaire was a feasible and useful strategy for screening those conditions |
| **Tapia et al. 2021** | USA | Cross-sectional |  | depression, substance use, PTSD, AUD | elevation in rectal cytokines/chemokines | regression analysis using a summation score | Experiencing a greater number of syndemic conditions was associated with elevations in rectal cytokines relevant to HIV/STI acquisition |
| **Tomori et al. 2018** | India | Cross-sectional |  | depression, substance use, IPV, CSA, AUD | engaging in sexual risk behaviors, STI diagnosis | regression analysis using a summation score, Relative Excess Risk due to Interaction (RERI) | There is an additive relationship between the count of syndemic conditions and condomless sex but not with syphilis. As for interaction, RERI were significant only for IPV and depression for condomless anal sex and for alcohol dependence and substance use for syphilis |
| **Tulloch et al. 2015** | Canada | Cross-sectional |  | depression, IPV, polysubstance use | engaging in sexual risk behaviors | regression analysis using a summation score, mediation analysis | The number of syndemic conditions mediated the relationship between childhood physical abuse and sexual risk as well as between verbal victimization and sexual risk |
| **Turpin et al. 2020a** | USA | Cross-sectional | Young MSM | depression, substance use, IPV, bullying, violence | engaging in sexual risk behaviors | Latent Class Analysis/Latent Profile Analysis | A syndemic of victimization, sexual violence, IPV, substance use and depression was identified in a latent profile comprising 1/8th of the sample. This profile was strongly associated with substance use at last sexual intercourse and number of partners but not with condom use. |
| **Turpin et al. 2020b** | USA | Longitudinal (12 months) | Black MSM | depression, substance use, IPV, internalised homophobia, discrimination, poor social support, experience of trauma | substance use | Latent Transition Analysis | Using latent transition analysis, three profiles of high-risk syndemic status with different proportions of syndemic factors and a low risk profile were identified. Moreover, social support strongly moderated the association between these profiles and substance use at 12 months in that BMSM with better social support had more chance to stay in the low risk profile or to transition from high risk to low risk. |
| **Vanden Berghe et al. 2014** | Belgium | Cross-sectional |  | depression, sexual risk behaviors, chemsex | engaging in sexual risk behaviors | moderation analysis | Depressive symptoms and sexual sensation seeking were more present in MSM who engaged in condomless anal sex in the past 6 months while use of alcohol or substance or alcohol just before or during sex was not. However, this study found no evidence that depressive symptoms moderated the effect of risk perception of condomless anal sex on engaging in condomless anal sex. |
| **Walters et al. 2020** | USA | Cross-sectional | MSM living with HIV | depression, IPV, polysubstance use | engaging in exchange sex | regression analysis using a summation score | Exchange sex was associated with being a Black MSM, < 30 years, annual incomes < 20.000$, recent depressive symptoms, polydrug use, stimulant use and having experienced past and present IPV |
| **Wang et al. 2017** | China | Cross-sectional |  | depression, sexual compulsivity, anxiety, loneliness, low self-esteem | engaging in sexual risk behaviors | regression analysis using a summation score | In this sample of MSM living in China, a significant proportion of respondent had at least two syndemic conditions which was associated with higher odds of engaging in condomless anal sex |
| **Wang et al. 2018** | China | Cross-sectional |  | depression, sexual compulsivity, anxiety, poor social support, loneliness, involuntary subordination, low self-esteem | engaging in sexual risk behaviors | regression analysis using a summation score | Syndemic conditions are additively associated with multiple sex partners |
| **Wu Elwin 2018** | USA | Cross-sectional | Black MSM | substance use, IPV, binge drinking, CSA, sexual risk behaviors |  | regression analysis using a summation score | CSA is an important antecedent in the formation of a syndemic in black MSM in the USA |
| **Yu et al. 2013** | China | Cross-sectional |  | depression, substance use, IPV, alcohol use, tobacco use | engaging in sexual risk behaviors | multivariate linear regression | High prevalence of smoking was found in this sample of Chinese MSM and the level of smoking was associated with alcohol use, substance use and depressive symptoms. Furthermore, sexual risk taking was positively associated with smoking, alcohol use, substance use and IPV |
| **Zepf et al. 2020** | USA | Cross-sectional | Older MSM living with HIV | depression, substance use, PTSD, IPV, binge drinking, violence | adherence to antiviral medication | regression analysis using a summation score | Experiencing syndemic conditions is associated with decreased medication adherence ; PTSD and stiulant use had the strongest influence on medication adherence in the final model. |
| **Zhang et al. 2019** | USA | Longitudinal (12 months) | Black MSM | depression, IPV, CSA, AUD, unemployment, substance use disorder | physical activity | regression analysis using a summation score, moderation analysis | Number of syndemic conditions at baseline predicted lower levels of physical activity. No synergistic interaction was found. No evidence of a moderating effect of resilience on the relationship between syndemic conditions and physical activity |

**Table 9.2:** Reference table of the included quantitative studies

| **References** | **Location** | **Analysis method** | **Subpopulation** | **Bio-social interaction** | **Key findings** |
| --- | --- | --- | --- | --- | --- |
| **Adam et al. 2017** | Canada | thematic analysis |  |  | Life story interviews of MSM affected by at least two syndemic conditions revealed one major pathway of syndemic production (childhood adversity leading to depression, substance abuse and risk taking) and two minor modes characterised by migration stress or transition stress from home to college or work. Furthermore, risk practice fell into different subjectivities (active and consistent pursuit of condomless sex, lack of assertiveness to a partner's initiative of CAS and combination of risk reduction strategies) |
| **Adam et al. 2018** | Canada | comparative |  |  | Some of the men interviewed in this study found safety from family in school but a more sizeable part encoutered bullying which compounded their distress at home. Furthermore, some found refuges from hostile home and school environment through books, pop culture and internet chat. Finally, during adolescence a subset of men experienced sexual relationships with older men who brought emotional stability and personal growth |
| **Bruce et al. 2011** | USA | thematic analysis, cross case analysis | Young MSM living with HIV |  | The results of this study suggests links between experiences of marginalization in childhood/aolescence and subsequent search for gay peers and migration to larger city and/or gay neighboorhood. This migration exposes YMSM to a range of risk factors such as experimentation with substance and sex. Compared to straight youth, this risk may be heightened due to lack of support. On the other hand, access to gay spaces also offers resilience resources such as a sense of community and peer support. |
| **Cassels et al. 2020** | USA | thematic analysis | Latino & Black MSM |  | Geographic mobility represents a syndemic condition in itself as it was found to magnify many HIV risk factors such as racism, lack of social cohesion or place attachement, barriers to HIV care and high-risk sexual encounters. When, geographic mobility was tied with housing instability, its direct contribution to the syndemic was found to be above and beyond its role in housing insecurity |
| **Chakrapani et al. 2019** | India | framework analysis |  | Multiple forms of intersecting stigma (i.e. same-sex sexuality, gender non-conformity, sex work and socio-economic stigmas) contribute to the production of syndemic conditions (i.e. depression, suicidality, internalized homonegativity, violence and problematic alcohol use as a coping strategy) which in turn increase HIV risk. Family support and communities of MSM may serve as a resilience resource and counteract the negative effects of stigma and syndemic conditions. | Intersecting stigma related to same-sex attraction, gender non-conformity and sex work contribute to the production of syndemic conditions which may in turn increase sexual risk behaviors. Family and community of MSM may serve as resilience and counteract the effects of stigma and syndemic conditions |
| **Lyons et al. 2013** | USA | grounded theory | Young MSM living with HIV | The marginalization of YMSM within their school, communities of origin and families result in a lack of gay-specific HIV prevention education, role model and productive goal-related activities, all of them being linked to HIV infection. | Alcohol use, substance use, marginalization, family rejection, lack of social support and lack of gay-specific HIV prevention as well as role models contributed to the HIV infection in YMSM. |
| **Maionara et al. 2020** | USA | thematic analysis | Young Black MSM | Economic dependency and fear of violence may maintain YBMSM in dysfunctional relationships plagued by intimate partner violence and substance abuse which increase their odds of incarceration and HIV infection. Their criminal records may then prevent YBMSM from achieving formal employment. Methamphetamine is a way of coping with this structural violence and eventual HIV diagnosis but represents a potential factor in transmitting HIV to others, notably during sex parties. | Methamphetamine use, intimate partner violence and incarceration may form a syndemic in the lives of young black men who have sex with men, increasing their vulnerability of acquiring or transmitting HIV |
| **Pollard et al. 2018** | England | framework analysis |  | Maladaptive coping strategies to minority stress and the performative resistant space of the gay scene contribute to chemsex use and HIV risks | The experience of chemsex and HIV-risk is entangled in complex narratives in which drug use is related to marginalisation, loneliness and a gay scene that acted both as a space of personal affirmation and resistance and as a barrier to fulfilling psychosocial needs such as meaningful emotional conections. |
| **Quinn 2019** | USA | thematic content analysis | Black MSM | Intersectional structural violence (e.g. racial neighborhood segregation, poverty, unemployment, violence, unstable housing, incarceration and poor healthcare access) leads to expectations surrounding masculinity which conflicts with the sexual orientation of BMSM and results in internalized homophobia. Internalized homophobia, in turn, produce poor mental health, suicidal ideation as well as substance abuse and sexual risk taking as a coping mechanism. Furthermore, the use of PrEP, perceived as a “gay pill” is less often considered. This all leads to an increase in HIV infection. | Intersectionality provides the context needed to understand syndemics among BMSM, which differs from syndemics among white MSM due to intersecting stigma and harmful social conditions unique to BMSM. These structural inequities, notably racial neighborhood segregation, shape the expectations surrounding masculinity, which result in societal and internalized homophobia, producing distress, depression, suicidal ideation, substance use and HIV risk behavior. |
| **Reed et al. 2016** | USA | analytic induction | Young Black MSM |  | Young Black MSM experimenting syndemic conditions have more conflicted identities, notably between their racial and sexual identities, and are disconnected both from their family and the gay community. Sense of community may thus be an important mediator between adversity and syndemics |

**Table 9.3:** Reference table of the included qualitative studies

| **References** | **Design** | **Purpose of the review** | **Number of included studies** | **Key findings** |
| --- | --- | --- | --- | --- |
| **Lassiter et al. 2016** | Systematic review | Examining the effects of spirituality and religion on MSM's health and proposing a framework for integrating these factors into HIV research with MSM | 9 | Religion and spirituality have mixed effect on syndemic conditions of MSM but may be more beneficial for the health of MSM of color than for white MSM. All in all, religion and spirituality was completey absent from syndemic quantitative research and very sparse in syndemic conditions research focused on MSM |
| **Lewis and Wilson 2017** | Systematic review | Examine the HIV prevalence and associated risk behaviours among migrant and ethnic minority MSM in North America and Europe | 24 | Ethnic minority MSM are faced with high rates of HIV prevalence and associated risk factors such as substance use and condomless anal sex. Furthermore, the high prevalence of these factors in samples comprised mostly or entirely of immigrant MSM gives credit to the hypothesis that transational migration is part of a syndemic. |
| **Pantalone et al. 2020** | Systematic review and meta-analysis | To have a better understanding of the state of interventions co-targeting interrelated syndemic conditions and HIV-related health behaviors of sexual minority men | 43 | The meta-analysis showed a small significant positive effect of combined behavioral interventions to improve syndemic conditions (mental health, drug and alcohol use ; d=0.20) and sexual risk behaviors (d=0.16) with significant heterogeneity. More sessions (9 or more) and individual rather than group interventions showed grater efficacy. |
| **Rooney et al. 2018** | Meta-analysis | (1) Determine which syndemic conditions are significantly associated with sexual compulsivity among MSM ; (2) calculate the mean effect size of these conditions with sexual compulsivity; (3) determine if this effect varies as a function of the type of syndemic condition | 36 | Sexual compulsivity was significantly associated with 7 syndemic indicators (anxiety, depression, childhood sexual abuse, alcohol use, substance use, interpartner violence and sexual risk. The two strongest associations were with depression and anxiety |
| **Woodward et al. 2016** | Systematic review | Identify a set of resilience ressources among MSM burdened with minority stress and psychosocial conditions which may improve HIV prevention | 20 | 31 resilience ressources were identified, with the most frequently cited being social support and incomes. Most of these resources were associated with a lower HIV risk. |

**Table 9.4:** Reference table of the included reviews

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## C. Measurement tables

| **Use of a scale or a criteria** | **Number of studies** | **Scale or criteria used** | **Number of studies** | **Cutoff used** | **References** |
| --- | --- | --- | --- | --- | --- |
| Scale | 70 | CESD | 26 | 16 | **Zhang et al. 2019** |
| **Morrison et al. 2018** |
| **Wang et al. 2017** |
| **Friedman et al. 2016** |
| **Tulloch et al. 2015** |
| **Friedman et al. 2015** |
| **Herrick et al. 2014** |
| **Herrick et al. 2013** |
| **Dyer et al. 2012** |
| **Tan et al. 2016** |
| **Ng et al. 2020** |
| **Mimiaga et al. 2021** |
| 22 | **Vanden Berghe et al. 2014** |
| 23 | **Wang et al. 2018** |
| **Parsons et al. 2017** |
| **Hart et al. 2017** |
| **Li et al. 2016** |
| **Starks 2014** |
| **Jie et al. 2012** |
| **Parsons et al. 2012** |
| **Stall et al. 2003** |
| 27 | **Carrico et al. 2018** |
| Continuous | **Hugh Klein 2011** |
| **Turpin et al. 2020b** |
| **Dyer et al. 2020** |
|  | **Leblanc et al. 2021** |
| CESD-10 | 11 | 10 | **Chandler et al. 2020a** |
| **Ogunbajo et al. 2019** |
| **Chandler et al. 2020b** |
| **Martinez et al. 2016** |
| **Biello et al. 2016** |
| **Mimiaga et al. 2015a** |
| **Biello et al. 2014** |
| **Shuper et al. 2020** |
| **Chandler et al. 2020c** |
| **Sullivan and Eaton 2020** |
| **Tapia et al. 2021** |
| PHQ-9 | 9 | 10 | **Zepf et al. 2020** |
| **Nostlinger et al. 2020** |
| **Harkness et al. 2019** |
| **Tomori et al. 2018** |
| 15 | **McDaid et al. 2019** |
| 5 | **Chakrapani et al. 2020** |
| **Safren et al. 2018** |
| **Satyanarayana et al. 2021** |
| Having at least 5 positive items in addition to the depressed mood and/or loss of interest items | **Harkness et al. 2018** |
| BDI-II | 5 | 16 | **Halkitis et al. 2012** |
| 17 | **Pitpitan et al. 2016** |
| Continuous | **Semple et al. 2017** |
| **Halkitis et al. 2015** |
| **Halkitis et al. 2013** |
| Depression subscale of the Brief Symptom Inventory | 4 | 0.5 (raw-score) | **Parsons et al. 2015** |
| 0.8 (raw score) | **Muñoz-Laboy et al. 2018** |
| 65 (T-score) | **Starks et al. 2016** |
| Not specified | **Moeller et al. 2011** |
| PHQ-2 | 3 | 3 | **Walters et al. 2020** |
| **Hirshfield et al. 2015** |
| **Santos et al. 2014** |
| PHQ-8 | 3 | 10 | **Blashill et al. 2020** |
| Continuous | **Lee et al. 2020a** |
| **Lee et al. 2020b** |
| HADS | 2 | 10 | **Card et al. 2018** |
| 8 | **Achterbergh et al. 2021** |
| Zung Self Rating Depression Scale | 2 | 0.5 | **Jiang et al. 2020** |
| 40 | **Oginni et al. 2019** |
| BDI-FS | 1 | 7 | **Chakrapani et al. 2017** |
| CESD-12 | 1 | 10 | **Yu et al. 2013** |
| CESD-5 | 1 | 1 | **O'Leary et al. 2014** |
| CESD-SF | 1 | 13 | **Mimiaga et al. 2015b** |
| The Depression Symptom Scale (DSS-9) | 1 | Not specified | **Friedman et al. 2014** |
| Criteria | 10 | Being on medication for depression in the last 12 months | | | **Ferlatte et al. 2015** |
| **Brandstrom and Pachankis 2018** |
| **Ferlatte et al. 2018b** |
| Clinical diagnosis based on the DSM-IV | | | **Batchelder et al. 2019** |
| **Mustanski et al. 2017** |
| During the past 12 months having felt so sad or hopeless almost every day for 2 weeks in a row that the respondent stopped doing some usual activities | | | **Turpin et al. 2020a** |
| **Mustanski 2014** |
| Feeling snap and unable to snap out of it for most of the time or being in treatment for depression | | | **Ferlatte et al. 2014** |
| Medical diagnosis of depression in the EMR | | | **Byg et al. 2016** |
| Self-report of a medical diagnosis | | | **Reisner et al. 2016** |

**Table 9.5:** Summary of the studies including depression or depressive symptoms as a syndemic condition and the criteria used to screen this condition

| **Use of a scale or a criteria** | **Number of studies** | **Type(s) of violence screened or scale used** | **Number of studies** | **Reference period or cutoff used** | **References** |
| --- | --- | --- | --- | --- | --- |
| Criteria | 40 | physical IPV, sexual IPV, psychological IPV | 14 | Past year | **Oginni et al. 2019** |
| Past 6 months | **Turpin et al. 2020b** |
| Past 5 years | **Biello et al. 2016** |
| **Starks et al. 2016** |
| **Mimiaga et al. 2015a** |
| **Parsons et al. 2015** |
| **Stall et al. 2003** |
| **Achterbergh et al. 2021** |
| **Bulled et al. 2021** |
| **Chuang et al. 2021** |
| Lifetime | **Lee et al. 2020a** |
| **Safren et al. 2018** |
| **Mustanski et al. 2007** |
| **Dyer et al. 2020** |
| physical IPV, psychological IPV | 8 | Past 5 years | **Starks 2014** |
| **Herrick et al. 2013** |
| **Dyer et al. 2012** |
| **Parsons et al. 2012** |
| Past 12 months | **McDaid et al. 2019** |
| **Ferlatte et al. 2018a** |
| Not specified | **Jie et al. 2012** |
| Lifetime | **Walters et al. 2020** |
| physical IPV | 7 | Past month | **Mustanski 2014** |
| Past 4 months | **Eaton et al. 2013** |
| Past 12 months | **Chandler et al. 2020a** |
| **Chandler et al. 2020b** |
| **Chandler et al. 2020c** |
| Lifetime | **Tomori et al. 2018** |
| **Tulloch et al. 2015** |
| physical IPV, sexual IPV | 6 | Past 6 months | **Mustanski et al. 2017** |
| Lifetime | **Turpin et al. 2020a** |
| **OCleirigh et al. 2018** |
| **O'Leary et al. 2014** |
| **Ng et al. 2020** |
| **Reisner et al. 2016** |
| physical IPV, sexual IPV, psychological IPV, gay-related IPV | 2 | Past 5 years | **Jiang et al. 2020** |
| Lifetime | **Chuang et al. 2018** |
| Not specified | 2 | Not specified | **Byg et al. 2016** |
| Lifetime | **Beymer et al. 2016** |
| physical IPV, sexual IPV, psychological IPV, gay-related IPV, HIV-related IPV | 1 | Past month | **Wu Elwin 2018** |
| Scale | 7 | HITS | 3 | Continuous | **Lee et al. 2020b** |
| 11 | **Zepf et al. 2020** |
| **Blashill et al. 2020** |
| CTS2 | 3 | Responding yes to at least one item | **Parsons et al. 2017** |
| Not specified | **Zhang et al. 2019** |
| Continuous | **Pantalone et al. 2018** |
| Authors' scale (physical and psychological) | 1 | continuous | **Yu et al. 2013** |
| Physical intimate partner violence: 38 studies ; 81% of studies with IPV as a syndemic condition | | | | | |
| Psychological intimate partner violence: 25 studies ; 53% of studies with IPV as a syndemic condition | | | | | |
| Sexual intimate partner violence: 23 studies ; 49% of studies with IPV as a syndemic condition | | | | | |
| Gay-related intimate partner violence: 3 studies ; 6% of studies with IPV as a syndemic condition | | | | | |
| HIV-related intimate partner violence: 1 studies ; 2% of studies with IPV as a syndemic condition | | | | | |

**Table 9.6:** Summary of the studies including intimate partner violence as a syndemic condition and the criteria used to screen this condition

| **Type of substances screened** | **Number of studies** | **Reference period** | **References** |
| --- | --- | --- | --- |
| stimulants | 9 | Past month | **Zepf et al. 2020** |
| Past 6 months | **Mimiaga et al. 2015b** |
| **Herrick et al. 2013** |
| **Dyer et al. 2020** |
| **Chuang et al. 2021** |
| **Mimiaga et al. 2021** |
| Past 3 months | **Harkness et al. 2019** |
| **Harkness et al. 2018** |
| **Tapia et al. 2021** |
| stimulants, ecstasy, hallucinogens, marijuana, depressants, opioids, inhalants | 4 | Past month | **Halkitis et al. 2015** |
| **Halkitis et al. 2013** |
| Past 6 months | **Bulled et al. 2021** |
| Past 3 months | **Storholm et al. 2011** |
| stimulants, ecstasy, hallucinogens, depressants | 4 | Past 4 months | **Moeller et al. 2011** |
| Past 12 months | **Ferlatte et al. 2015** |
| **Ferlatte et al. 2018a** |
| **Ferlatte et al. 2018b** |
| stimulants, marijuana, opioids | 3 | Past month | **Semple et al. 2017** |
| Past 3 months | **Wu Elwin 2018** |
| Lifetime | **Oginni et al. 2019** |
| stimulants, opioids | 2 | Past 6 months | **OCleirigh et al. 2018** |
| **Tomori et al. 2018** |
| stimulants, depressants, opioids, inhalants | 2 | **Turpin et al. 2020b** |
| **Leblanc et al. 2021** |
| not\_specified | 2 | Past month | **Biello et al. 2014** |
| Past 12 months | **Santos et al. 2014** |
| marijuana | 2 | Past month | **Blashill et al. 2020** |
| Lifetime | **Perry et al. 2019** |
| stimulants, marijuana, inhalants | 1 | Past 4 months | **Eaton et al. 2013** |
| stimulants, marijuana | 1 | Past month | **Mustanski 2014** |
| stimulants, inhalants | 1 | Past 3 months | **Sullivan and Eaton 2020** |
| stimulants, hallucinogens, marijuana, depressants, inhalants | 1 | Lifetime | **Shuper et al. 2020** |
| stimulants, hallucinogens, depressants, opioids, inhalants | 1 | Past 3 months | **Lee et al. 2020a** |
| stimulants, hallucinogens, depressants, opioids | 1 | Past month | **Lee et al. 2020b** |
| stimulants, hallucinogens, depressants, NPS, opioids | 1 | Lifetime | **Ogunbajo et al. 2019** |
| stimulants, hallucinogens, depressants, NPS | 1 | Past 3 months | **Nostlinger et al. 2020** |
| stimulants, ecstasy, opioids, inhalants | 1 | Past 6 months | **Dyer et al. 2012** |
| stimulants, ecstasy, NPS, opioids | 1 | Lifetime | **Turpin et al. 2020a** |
| stimulants, ecstasy, marijuana, depressants, opioids | 1 | **Yu et al. 2013** |
| stimulants, ecstasy, marijuana | 1 | **Li et al. 2016** |
| stimulants, ecstasy, inhalants | 1 | Past 12 months | **Beymer et al. 2016** |
| stimulants, ecstasy, hallucinogens, marijuana, depressants, opioids | 1 | Past month | **Hugh Klein 2011** |
| stimulants, ecstasy, hallucinogens, marijuana, depressants | 1 | Past 12 months | **Mustanski et al. 2007** |
| stimulants, ecstasy, hallucinogens, depressants, opioids, inhalants | 1 | Lifetime | **Pitpitan et al. 2016** |
| stimulants, ecstasy, hallucinogens, depressants, opioids | 1 | Past 3 months | **Herrick et al. 2014** |
| stimulants, ecstasy, hallucinogens, depressants, inhalants | 1 | Past 4 months | **Guadamuz et al. 2014** |
| marijuana, opioids | 1 | Past 12 months | **Chakrapani et al. 2019b** |
| marijuana, inhalants | 1 | Past month | **Halkitis et al. 2012** |
| Stimulants : cocaine/crack, amphetamine (42 studies ; 88%) | | | |
| Ecstasy (18 studies ; 38%) | | | |
| Hallucinogens : ketamine, psilocybine, phencyclidine (18 studies ; 38%) | | | |
| Marijuana (18 studies ; 38%) | | | |
| Depressants : GHB/GBL, benzodiazebines (21 studies ; 44%) | | | |
| NPS : New Psychoactive Substances : synthetic cannabinoids, cathinones (3 studies ; 6%) | | | |
| Opioids : opioids misuse, heroin (21 studies ; 44%) | | | |
| Inhalants : nitrous oxyde, Popper : (15 studies ; 31%) | | | |

**Table 9.7:** Summary of the studies including substance use as a syndemic condition and the substances specifically screened in the studies

| **Use of a scale or a criteria** | **Number of studies** | **Scale or criteria used1** | **Number of studies** | **Cutoff used** | **References** |
| --- | --- | --- | --- | --- | --- |
| Definition | 31 | Finkelhor definition | | | **Lee et al. 2020a** |
| **Blashill et al. 2020** |
| **Lee et al. 2020b** |
| **Harkness et al. 2019** |
| **Safren et al. 2018** |
| **Harkness et al. 2018** |
| **Mimiaga et al. 2015b** |
| Any unwanted sexual experience before 18 years old | | | **Semple et al. 2017** |
| **Biello et al. 2016** |
| **Starks et al. 2016** |
| **Mimiaga et al. 2015a** |
| **Biello et al. 2014** |
| **Ng et al. 2020** |
| **Mimiaga et al. 2021** |
| Any unwanted sexual experience before 17 years old with someone at least 10 years older | | | **Parsons et al. 2015** |
| **Starks 2014** |
| **Parsons et al. 2012** |
| **Stall et al. 2003** |
| **Bulled et al. 2021** |
| Any unwanted sexual experience before 15 years old | | | **OCleirigh et al. 2018** |
| **Reisner et al. 2016** |
| Having experienced unwanted sexual activity with someone older at 16 years old or younger | | | **Parsons et al. 2017** |
| Having experienced sexual abuse as a child | | | **Eaton et al. 2013** |
| Any unwanted sexual experience before 17 years old | | | **Martinez et al. 2016** |
| Any unwanted sexual experience before 16 years old with someone at least 5 years older | | | **Jie et al. 2012** |
| Any unwanted sexual experience before 16 years old | | | **Tomori et al. 2018** |
| Any unwanted sexual experience before 13 years old | | | **Mustanski et al. 2017** |
| Any sexual experience before 18 years old with someone at least 5 years older or any unwanted sexual experience with an adult before 18 years old | | | **Chuang et al. 2021** |
| Any sexual experience before 13 years old with someone at least 4 years older | | | **Muñoz-Laboy et al. 2018** |
| Any sexual experience before 12 years old, any unwanted sexual experience between 12 years old and 16 years old or any sexual experience with an adult or someone at least 5 years older before 16 years old | | | **Jiang et al. 2020** |
| Any sexual experience before 11 years old, any unwanted sexual experience between 11 years old and 17 years old or any sexual experience with someone at least 4 years older before 17 years old | | | **Wu Elwin 2018** |
| Scale | 6 | CTQ Sexual Abuse subscale | 3 | 5 | **Perry et al. 2019** |
| **Hart et al. 2017** |
| 13 | **Carrico et al. 2018** |
| WSHQ-CSA | 2 |  | **Zhang et al. 2019** |
| **O'Leary et al. 2014** |
| Sexual abuse subscale of the Childhood Maltreatment Interview Schedule - Short Form (CMIS-SF) | 1 | Endorsement of any one item | **Pantalone et al. 2018** |
| 1Finkelhor definition : any sexual experience before 13 years old with someone at least 5 years older or any sexual experience between 13 and 17 years old with someone at least 10 years older (Finkelhor 1994) | | | | | |

**Table 9.8:** Summary of the studies including childhood sexual abuse as a syndemic condition and the criteria used to screen this condition

| **Number of substances to qualify as polysubstance use** | **Number of studies** | **Inclusion of marijuana in the substances count** | **Reference period** | **References** |
| --- | --- | --- | --- | --- |
| At least 3 categories of substance use | 16 | Marijuana not included | Past month | **Blashill et al. 2020** |
| Past 3 months | **Chandler et al. 2020a** |
| **Chandler et al. 2020b** |
| Past 12 months | **Pantalone et al. 2018** |
| Marijuana included | Past 6 weeks | **Parsons et al. 2015** |
| Past 6 months | **Card et al. 2018** |
| **Tulloch et al. 2015** |
| **Stall et al. 2003** |
| Past 4 months | **Muñoz-Laboy et al. 2018** |
| Past 3 months | **Harkness et al. 2019** |
| **Harkness et al. 2018** |
| **Parsons et al. 2017** |
| **Starks 2014** |
| **Parsons et al. 2012** |
| Past 2 months | **Hirshfield et al. 2015** |
| Past 12 months | **Reisner et al. 2016** |
| More than one category of substance use | 9 | Marijuana not included | Past 3 months | **Walters et al. 2020** |
| **Hart et al. 2017** |
| Marijuana included | Past 6 months | **Mustanski et al. 2017** |
| **Friedman et al. 2016** |
| **Friedman et al. 2015** |
| **Jie et al. 2012** |
| Past 3 months | **Starks et al. 2016** |
| **Scheer et al. 2021** |
| **Chandler et al. 2020c** |
| At least 3 categories of substance, excluding stimulants | 2 | Marijuana included | Past 6 months | **Mimiaga et al. 2015b** |
| **Mimiaga et al. 2021** |

**Table 9.9:** Summary of the studies including polysubstance use as a syndemic condition and the criteria used to screen this condition

| **Number of episodes to qualify as binge drinking** | **Number of studies** | **Reference period** | **References** |
| --- | --- | --- | --- |
| At least one episode | 12 | Past month | **Blashill et al. 2020** |
| **Martinez et al. 2020** |
| **Martinez et al. 2016** |
| **Herrick et al. 2014** |
| Past 6 months | **Mustanski et al. 2017** |
| **Jie et al. 2012** |
| **Dyer et al. 2012** |
| **Reisner et al. 2016** |
| **Dyer et al. 2020** |
| Past 3 months | **Lee et al. 2020a** |
| **Wu Elwin 2018** |
| Past 12 months | **Zepf et al. 2020** |
| At least one per week, every week | 4 | Past 3 months | **Harkness et al. 2019** |
| **Harkness et al. 2018** |
| Past 12 months | **Mustanski et al. 2007** |
| **Ferlatte et al. 2018b** |
| At least one per month | 2 | Past 12 months | **Chandler et al. 2020a** |
| **Chandler et al. 2020b** |
| More than one per week, every week | 2 | Past 12 months | **Brandstrom and Pachankis 2018** |
| **Ferlatte et al. 2018a** |
| At least 3 episodes | 1 | Past month | **Mustanski 2014** |
| Having at least 4 drinks everyday or at least 6 drinks on a typical drinking day | 1 | Not specified | **Mimiaga et al. 2015b** |

**Table 9.10:** Summary of the studies including binge drinking as a syndemic condition and the criteria used to screen this condition

| **Type(s) of violence screened** | **Number of studies** | **violence\_period** | **References** |
| --- | --- | --- | --- |
| sexual | 5 | Past 4 months | **Eaton et al. 2013** |
| Lifetime | **Turpin et al. 2020a** |
| **Guadamuz et al. 2014** |
| **Biello et al. 2014** |
| **Mustanski et al. 2007** |
| physical, sexual, psychological | 5 | Past 6 months | **Mimiaga et al. 2021** |
| Past 12 months | **Friedman et al. 2014** |
| Lifetime | **Pitpitan et al. 2016** |
| **Buttram et al. 2015** |
| **Kurtz et al. 2012** |
| physical, sexual | 2 | Past 12 months | **Chakrapani et al. 2019b** |
| Lifetime | **Zepf et al. 2020** |
| physical | 2 | Past 12 months | **Chandler et al. 2020c** |
| Lifetime | **Brandstrom and Pachankis 2018** |
| physical, sexual harassment by police, physical harassment by police | 1 | Not specified | **Chakrapani et al. 2017** |
| physical, psychological | 1 | Past 12 months | **Santos et al. 2014** |
| not specified | 1 | Lifetime | **Leblanc et al. 2021** |
| Physical violence: 11 studies ; 65% of studies with violence as a syndemic condition | | | |
| Psychological violence: 6 studies ; 35% of studies with violence as a syndemic condition | | | |
| Sexual violence: 12 studies ; 71% of studies with violence as a syndemic condition | | | |
| Physical harassment by the Police: 1 studies ; 6% of studies with violence as a syndemic condition | | | |
| Sexual harassment by the Police: 1 studies ; 6% of studies with violence as a syndemic condition | | | |

**Table 9.11:** Summary of the studies including violence as a syndemic condition and the criteria used to screen this condition

| **Type of anxiety disorder screened, if specified** | **Number of studies** | **Criteria or scale used** | **Number of studies** | **Reference period or cutoff used** | **References** |
| --- | --- | --- | --- | --- | --- |
| not specified | 5 | Being on medication for anxiety | 2 | Past 12 months | **Ferlatte et al. 2015** |
| **Ferlatte et al. 2018b** |
| BSI | 1 | Not specified | **Moeller et al. 2011** |
| Self-report of having an anxiety disorder | 1 |  | **Reisner et al. 2016** |
| HADS | 1 | 8 | **Achterbergh et al. 2021** |
| generalized anxiety disorder | 4 | GAD-7 | 4 | 10 | **McDaid et al. 2019** |
| **Wang et al. 2018** |
| **Wang et al. 2017** |
| **Li et al. 2016** |
| social phobia, panic disorder, generalized anxiety disorder | 3 | MINI-SPIN, PHQ | 2 |  | **Harkness et al. 2019** |
| **Harkness et al. 2018** |
| Clinical diagnosis based on the DSM-IV | 1 | **Batchelder et al. 2019** |
| social phobia | 2 | SPIN | 2 | 19 | **Lee et al. 2020a** |
| **Safren et al. 2018** |
| panic disorder | 1 | PHQ-5 | 1 | Any anxiety attack in the previous four weeks | **Satyanarayana et al. 2021** |

**Table 9.12:** Summary of the studies including anxiety as a syndemic condition and the criteria used to screen this condition