



Sexual behaviors, knowledge about STI, and health care access among young heterosexual and homosexual men^a

Condutas sexuais, conhecimento sobre IST e acesso à saúde entre homens jovens heterossexuais e homossexuais

Conductas sexuales, conocimiento sobre ITS y acceso a la salud entre hombres jóvenes heterossexuales y homossexuais

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ABSTRACT

Objective: to comparatively analyze sexual behaviors, knowledge about Sexually Transmitted Infections (STIs), and access to health services among young heterosexual and homosexual men. **Method:** a descriptive, cross-sectional, and quantitative study conducted with 200 young men aged 18 to 29 years (100 heterosexuals and 100 homosexuals) in social settings in Rio de Janeiro, Brazil. Data were collected through an anonymous questionnaire and analyzed using descriptive and inferential statistics.

Results: heterosexual young men presented a lower mean age and reported a higher proportion of stable affective relationships compared to homosexual men. Conversely, homosexual men showed higher educational levels, a greater number of sexual partners, and more frequent use of alcohol and other drugs before sexual intercourse. They also demonstrated closer contact with health services, undergoing more HIV and STI testing, and seeking professional counseling more often. Regarding condom use, the practice was irregular in both groups. **Conclusion and implications for the practice:** the findings highlight the need for inclusive sexual education, non-stigmatizing healthcare environments, and intersectional policies that promote health equity.

Keywords: Condoms; Health Services Accessibility; Men; Minority Groups; Sexually Transmitted Infections.

RESUMO

Objetivo: analisar comparativamente as condutas sexuais, o conhecimento sobre as Infecções Sexualmente Transmissíveis (ISTs) e o acesso aos serviços de saúde entre jovens homens heterossexuais e homossexuais. **Método:** estudo descritivo, transversal e quantitativo, realizado com 200 homens jovens de 18 a 29 anos (100 heterossexuais e 100 homossexuais) em locais de socialização na cidade do Rio de Janeiro, Brasil. Os dados foram coletados por meio de um questionário anônimo e analisados por meio de estatística descritiva e inferencial. **Resultados:** os jovens heterossexuais apresentaram idade média mais baixa e relataram maior proporção de relacionamentos afetivos estáveis quando comparados aos homossexuais. Por outro lado, os homossexuais destacaram-se por apresentarem níveis mais elevados de escolaridade, maior número de parceiros sexuais e maior frequência de consumo de álcool e de outras drogas antes da relação sexual. Além disso, demonstraram maior aproximação com os serviços de saúde, realizando-se mais testagens para HIV e outras ISTs, bem como buscando-se com mais frequência o aconselhamento de profissionais. No que se refere ao uso do preservativo, observou-se que a prática se apresenta irregular em ambos os grupos. **Conclusão e implicações para a prática:** os achados reforçam a necessidade de uma educação sexual inclusiva, acolhimento sem estigma e de políticas interseccionais que promovam a equidade em saúde.

Palavras-chave: Acessibilidade aos Serviços de Saúde; Grupos Minoritários; Homens; Infecções Sexualmente Transmissíveis; Preservativos.

RESUMEN

Objetivo: analizar comparativamente las conductas sexuales, conocimiento sobre Infecciones de Transmisión Sexual (ITS) y acceso a los servicios de salud entre hombres jóvenes heterossexuales y homossexuales. **Método:** estudio descriptivo, transversal y cuantitativo, realizado con 200 hombres de 18 a 29 años (100 heterossexuales y 100 homossexuales) en espacios de socialización de la ciudad de Río de Janeiro, Brasil. Los datos fueron recolectados mediante un cuestionario y analizados con estadística descriptiva e inferencial. **Resultados:** los jóvenes heterossexuales presentaron una edad media menor y relataron mayor proporción de relaciones afectivas estables en comparación con los homossexuales. Por otro lado, los homossexuales se destacaron por tener niveles educativos más altos, mayor número de parejas sexuales y mayor frecuencia de consumo de alcohol y otras drogas antes de la relación sexual. Además, mostraron una relación más estrecha con los servicios de salud, realizando más pruebas para VIH y otras ITS, así como buscando con mayor frecuencia la orientación de profesionales. En cuanto al uso del preservativo, se observó que la práctica es irregular en ambos grupos. **Conclusión e implicaciones para la práctica:** los hallazgos refuerzan la necesidad de una educación sexual inclusiva, atención sin estigma y políticas interseccionales que promuevan la equidad en salud.

Palabras clave: Accesibilidad a los Servicios de Salud; Condones; Enfermedades de Transmisión Sexual; Grupos Minoritarios; Hombres.

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INTRODUCTION

Sexually Transmitted Infections (STIs) continue to rank among the most relevant challenges in contemporary public health, particularly due to their high incidence, psychosocial impact, and potential clinical complications. According to the World Health Organization (WHO), millions of new cases are diagnosed annually, constituting a scenario that transcends geographic, cultural, and socioeconomic boundaries.¹ In the Brazilian context, epidemiological data reveal concerning trends, especially among the young population, an age group characterized by greater sexual experimentation, increased vulnerability to risk practices, and, often, limited access to qualified information and health services.²

Youth, defined as individuals aged 15 to 29 years according to the Youth Statute, corresponds to a period of intense biopsychosocial transformations, marked by experiences of identity affirmation, greater autonomy in affective-sexual choices, and exposure to situations of vulnerability. In this context, sexuality should not be analyzed solely as an individual dimension, but as a social construction shaped by gender norms, cultural representations, and power dynamics. Masculinities, in particular, directly influence sexual behaviors and how young individuals perceive their risk of acquiring STIs.³

The social construction of male sexuality exerts a decisive influence on ways of experiencing and preventing STIs. Gender norms, cultural expectations, and social representations of masculinity tend to shape sexual behaviors and may intensify exposure to risk situations. In this scenario, heterosexual and homosexual young men do not constitute homogeneous groups; experiences, preventive practices, and perceptions of vulnerability differ significantly, although both are subject to the same structural conditions of the health system. National and international studies have shown that homosexual men, for example, demonstrate greater familiarity with biomedical prevention technologies, such as pre- and post-exposure prophylaxis for HIV (PrEP and PEP), as well as a higher frequency of serological testing. On the other hand, they remain targets of stigma and discrimination, factors that may compromise adherence to care strategies. Among heterosexual young people, there is often a more limited perception of prevention, centered almost exclusively on condom use, combined with a lower recognition of their own vulnerability to HIV and other STIs.⁴⁻⁶

Another relevant aspect is access to health services. Despite advances in combined prevention policies and the expansion of testing and counseling services, inequalities related to gender, sexual orientation, and social inclusion persist. Structural barriers, such as limitations within the healthcare network, and subjective barriers, such as institutional prejudice, act unevenly on homosexual and heterosexual young people. In this sense, understanding how these groups construct their knowledge, practices, and health care trajectories is essential to support more equitable public policies and educational strategies that embrace diversity.⁷⁻⁹

Given this context, the objective was to comparatively analyze sexual behaviors, knowledge about STIs, and access to health services among heterosexual and homosexual young men. This investigation allows for the identification of convergences and divergences in the experiences of these groups, providing support for strengthening prevention and health promotion actions guided by equity and by the recognition of the specificities of each population.

METHOD

This is a descriptive study with a cross-sectional design and a quantitative approach. The research was conducted in youth socialization settings in the municipality of Rio de Janeiro, Brazil, intentionally selected to facilitate proximity between researchers and participants in everyday leisure and social environments. The data collection sites included: (a) bohemian streets in the neighborhoods of Tijuca and Vila Isabel, on soccer match days, on Sundays in the afternoon; (b) the surroundings of Maracanã Stadium, also on match days, on Sunday afternoons; (c) the Lapa neighborhood, a traditional hub of the city's nightlife, on Fridays and Saturdays at night (between 8:30 p.m. and 11:00 p.m.); and (d) Posto 8 on the Ipanema beach shoreline, on Saturdays and Sundays in the afternoon. These settings are located in the North, Central, and South zones of the city, allowing for the inclusion of different urban circuits of youth socialization.

The study population consisted of cisgender young individuals of heterosexual and homosexual orientation, aged between 18 and 29 years. The criterion adopted for defining youth was based on the Youth Statute, which considers individuals aged 15 to 29 years as young.³ However, to comply with ethical requirements regulating research involving human subjects, only individuals aged 18 years or older were included, thus avoiding the need for consent from legal guardians. Individuals who presented incomplete or inconsistent responses in the questionnaires, making statistical analysis unfeasible, were excluded from the sample.

A non-probabilistic convenience sampling method was adopted due to the difficulty in estimating the total population of young individuals with different sexual orientations. To ensure comparability between groups, a stratified and matched composition was established, with 50% heterosexual and 50% homosexual young individuals. It should be noted, however, that participants were selected based on their accessibility and availability at the data collection sites, without randomization criteria and therefore without the aim of statistical representativeness of the general population. Although refusal and loss rates were not systematically recorded, the team observed that most approached individuals agreed to participate after initial explanations.

The instrument used for data collection consisted of an anonymous questionnaire containing open- and closed-ended questions, specifically developed for this investigation. Its construction was based on a review of national and international

literature on youth, sexuality, STI prevention, and access to health services, as well as on instruments previously used in studies with young populations and men who have sex with men. The selection and formulation of items were discussed in systematic meetings of the research group, involving researchers with experience in the topic, aiming to ensure theoretical relevance, semantic clarity, and adequacy to the participants' sociocultural context.

The questionnaire's preliminary version was submitted to critical appraisal by faculty members and researchers during evaluation panels within the graduate program, constituting a stage of content validation by experts, from which adjustments were made to the wording, organization, and scope of the questions. Subsequently, a pre-test was conducted with 10 young individuals with a profile similar to that of the target population, in settings not included in the final data collection, to assess question comprehension, instrument flow, and application time in social environments. Pre-test participants were not included in the final sample. This stage allowed the identification of specific ambiguities and the refinement of language, resulting in the final version of the instrument.

It should be noted that, although the questionnaire underwent expert review and empirical pre-testing, it was not subjected to formal psychometric validation procedures or internal consistency analysis, which constitutes a methodological limitation of the study. In total, the questionnaire included 31 questions distributed across different thematic blocks: sociodemographic data (age, education, skin color, income, gender identity, sexual orientation, affective relationship status, marital status, employment, and religion); sexual behaviors (first sexual intercourse, sexual activity in the past 12 months, number of partners, and sexual habits); STIs prevention practices (condom use and access to biomedical methods such as PrEP and PEP); as well as knowledge about STIs and use of health services for prevention, diagnosis, and treatment.

Data collection took place between October 2022 and April 2023, conducted by a field team composed of three undergraduate research fellows and four master's students, all properly trained and supervised by the principal investigator. Participants were approached directly in the previously selected settings, on different days of the week, respecting the operational dynamics of each location. Considering the need to preserve appropriate approach conditions, data collection was not conducted on rainy days or when rain was forecast, as this could compromise both the quality of data and participants' adherence to the study.

The collected data were organized into an electronic database using Microsoft Excel 2003 and subsequently analyzed using the Statistical Package for the Social Sciences (SPSS), version 28.0. Qualitative variables were described using absolute and relative frequencies, while quantitative variables were presented using measures of central tendency and dispersion, including mean, Standard Deviation (SD), median, Interquartile Range (IQR), as well as 95% Confidence Intervals (95% CI) for the means.

For comparative analyses of categorical variables, Pearson's chi-square test was applied, with Fisher's exact test used in cases where expected frequencies were less than five in any cell of the table, with effect size estimated using Cramer's V.

Given the presence of asymmetric distributions, comparisons between groups were preferably performed using the nonparametric Mann-Whitney test, while maintaining the simultaneous presentation of means and medians for descriptive purposes. For continuous comparisons, the magnitude of differences between groups was estimated using Cohen's *d*. In all analyses, a significance level of 5% ($p < 0.05$) was adopted.

Regarding ethical aspects, the study strictly followed the guidelines established by Resolutions No. 466/2012 and No. 510/2016 of the Brazilian National Health Council (CNS), which regulate research involving human subjects. The project was submitted to and approved by the Research Ethics Committee (REC) of the proposing institution on September 29, 2022, receiving approval under opinion number 5,672,857 and CAAE 52805121.0.0000.5282. All participants were informed about the objectives, procedures, and possible risks and benefits of the research, and their participation was confirmed through the signing of the Free and Informed Consent Term (FICT).

RESULTS

A total of 200 young men participated in the study, equally distributed between heterosexual ($n=100$) and homosexual ($n=100$) individuals. The sociodemographic analysis (Table 1) revealed that most participants were in the 25 to 29 age group, characterizing them as young adults. However, when observing the distribution between groups, it was found that heterosexual individuals had a higher proportion of younger participants, with a predominance of 59.0% in the 18 to 24 age group, whereas among homosexual individuals, there was a greater concentration of older participants. This difference was also reflected in the mean ages: heterosexual individuals had a mean age of 23.57 years ($SD=3.32$, 95% CI 23.03–24.35), while homosexual individuals had a higher mean age of 25.93 years ($SD=2.93$, 95% CI 25.35–26.51), confirming the predominance of younger youth in the first group and young adults in the second group.

Regarding education, it was observed that most participants had 12 or more years of schooling; however, this condition was more pronounced among homosexual individuals, who presented higher levels of education compared to heterosexual individuals. Concerning affective relationships, it was identified that heterosexual individuals more frequently reported being in relationships (53%), whereas the majority of homosexual individuals declared not having an affective partner (66%). With respect to self-reported skin color, a difference between the groups was observed: 56% of heterosexual individuals identified as white, while among homosexual individuals, there was a predominance of those identifying as black (including both black and mixed-race), totaling 51% of the group. Regarding religion, most participants reported having no religious affiliation,

Table 1. Social profile of heterosexual and homosexual young men. Rio de Janeiro (RJ), Brazil. 2022–2023 (n=200).

Variables	Heterosexual young men		Homosexual young men		p	V
	f	%	f	%		
Age group						
18 to 24 years (young-young)	59	59.00	31	31.00	<0.001*	0.281
25 to 29 years (young-adults)	41	41.00	69	69.00		
Education (years of schooling)						
Up to 11 years old	32	32.00	11	11.00	<0.001*	0.256
12 years old or older	68	68.00	89	89.00		
Affective relationship status						
Does not have a girlfriend/boyfriend or steady partner	47	47.00	66	66.00	0.007*	0.201
Has a partner, but does not live with them	36	36.00	20	20.00		
Lives with a partner	17	17.00	14	14.00		
Skin color						
White	56	56.00	49	49.00	0.5*	0.082
Mixed-race	24	24.00	31	31.00		
Black	20	20.00	20	20.00		
Religion						
Catholic	19	19.00	17	17.00	<0.001 [†]	0.349
Evangelical	20	20.00	4	4.00		
Kardecist Spiritist	5	5.00	13	13.00		
Candomblé practitioner	-	-	4	4.00		
Umbanda practitioner	3	3.00	8	8.00		
No religion	33	33.00	36	36.00		
Does not believe in God	19	19.00	10	10.00		
Other	1	1.00	8	8.00		
Employment status						
Working for pay	66	66.00	76	76.00	0.001 [†]	0.210
Currently unemployed	21	21.00	22	22.00		
Never worked	13	13.00	2	2.00		
Total	100	100.00	100	100.00		

*Pearson's Chi-Square Test. [†]Fisher's exact test.

a condition indicated by 33% of heterosexual individuals and 36% of homosexual individuals. Finally, in terms of employment status, the majority reported being engaged in paid work, with a slightly higher proportion among homosexual individuals (76%) compared to heterosexual individuals (66%). Across all analyzed variables, the strength of association with sexual orientation was classified as weak.

Concerning sexual behaviors (Table 2), data showed that condom use is not a regular practice in either group. Nevertheless, it was found that, at first sexual intercourse, homosexual young men reported lower condom use compared to heterosexual

individuals, a pattern that persisted over time, particularly when considering use in all sexual encounters. Moreover, homosexual individuals reported a higher frequency of concurrent sexual relationships with more than one partner within the same period. In situations involving steady partners, condom use was less prevalent among homosexual individuals, whereas in casual relationships, heterosexual individuals demonstrated lower adherence. Both groups, however, reported attempting to negotiate condom use with their partners. It is also noteworthy that alcohol and other drug use before sexual intercourse was reported as a more common practice among homosexual young men.

Table 2. Sexual behaviors of heterosexual and homosexual young men. Rio de Janeiro (RJ), Brazil. 2022–2023 (n=200).

Variables	Heterosexual young men		Homosexual young men		p	V
	f	%	f	%		
Condom use at first sexual intercourse						
Yes	70	70.00	54	54.00	0.02*	0.165
No	30	30.00	46	46.00		
Condom use in all sexual encounters						
Always	50	50.00	38	38.00	0.01 [†]	0.198
Sometimes	41	41.00	59	59.00		
Never	9	9.00	3	3.00		
Sexual intercourse with more than one partner in the same period						
Yes	44	44.00	81	81.00	<0.001*	0.382
No	56	56.00	19	19.00		
Condom use with steady partners in the past 12 months						
Always	45	45.00	15	15.00	<0.001* [‡]	0.442
Never	16	16.00	24	24.00		
Sometimes	36	36.00	31	31.00		
Not reported	3	3.00	30	30.00		
Condom use with casual partners in the past 12 months						
Always	37	37.00	59	59.00	0.04**	0.451
Never	12	12.00	6	6.00		
Sometimes	17	17.00	33	33.00		
Not reported	34	34.00	2	2.00		
Negotiation of condom use with a sexual partner						
Always	20	20.00	30	30.00	0.2**	0.141
Never	47	47.00	38	38.00		
Sometimes	32	32.00	32	32.00		
Not reported	1	1.00	0	0.00		
Use of alcohol and/or other drugs before sexual intercourse						
Always	1	1.00	4	4.00	0.01 [†]	0.212
Never	56	56.00	36	36.00		
Sometimes	43	43.00	60	60.00		
Total	100	100.00	100	100.00		

*Pearson's Chi-Square Test. [†]Fisher's exact test. [‡]The adjusted p-value was used, disregarding the "not reported" category.

Regarding sexual initiation (Table 3), similarity between the groups was observed, as the mean age at first sexual intercourse was 16 years, with no significant difference identified. However, concerning the number of sexual partners in the past 12 months, a substantial discrepancy was found. Homosexual young men presented a mean of 8.70 partners during the period, in contrast to the mean of 1.15 partners reported by heterosexual individuals.

The analysis of access to health services (Table 4) revealed that, overall, homosexual young men sought health services more frequently than heterosexual individuals. This group showed higher rates of testing for HIV, syphilis, and viral hepatitis, as well as more frequently reporting the habit of seeking counseling

from health professionals. These findings reinforce the existence of greater engagement of homosexual individuals with health services, possibly due to more widespread preventive practices within this group.

Regarding knowledge about STIs (Table 5), a high level of familiarity among participants was identified: 98.5% reported having heard of the term, while 95.5% stated that they were aware of the modes of transmission. As for sources of information, the Internet and websites in general were mentioned as the most commonly used means for obtaining content related to prevention, highlighting the growing importance of the digital environment as a space for constructing knowledge about sexual health.

Table 3. Age at first sexual intercourse and number of sexual partners among heterosexual and homosexual young men. Rio de Janeiro (RJ), Brazil. 2022–2023 (n=200).

Variables	Heterosexual young men (n=100)	Homosexual young men (n=100)	p*	Cohen's d
Age at first sexual intercourse (years)	Mean: 16.30 (SD=2.46) 95% CI: 15.81–16.79 Median: 16 (IQR 15–17)	Mean: 16.23 (SD=3.15) 95% CI: 15.60–16.86 Median: 16 (IQR 14–18)	0.9	0.02
Number of sexual partners in the past 12 months	Mean: 1.14 (SD=0.60) 95% CI: 1.02–1.26 Median: 1 (IQR 1–1)	Mean: 8.70 (SD=10.41) 95% CI: 6.64–10.76 Median: 5 (IQR 4–10)	<0.001	1.03

*The Mann–Whitney test was used due to the asymmetry of the distributions.

Note: SD - Standard Deviation. 95% CI - 95% Confidence Interval. IQR - Interquartile Range.

Table 4. Access to health services among heterosexual and homosexual young men. Rio de Janeiro (RJ), Brazil. 2022–2023 (n=200).

Variáveis	Heterosexual young men		Homosexual young men		p	V
	F	%	f	%		
Usual source of health care						
Public service	42	42.00	49	49.00	<0.001 [†]	0.278
Private service	30	30.00	16	16.00		
Public and private services	19	19.00	34	34.00		
Does not usually seek care	9	9.00	1	1.00		
Testing for HIV, syphilis, and viral hepatitis						
Yes	51	51.00	85	85.00	<0.001*	0.364
No	49	49.00	15	15.00		
Habit of seeking health counseling with a health professional						
Yes	32	32.00	56	56.00	<0.001*	0.242
No	68	68.00	44	44.00		
Total	100	100.00	100	100.00		

*Pearson's Chi-Square Test. [†]Fisher's exact test.

Table 5. Knowledge about sexually transmitted diseases among heterosexual and homosexual young men. Rio de Janeiro (RJ), Brazil. 2022–2023 (n=200).

Variables	Heterosexual young men		Homosexual young men		P	V
	f	%	f	%		
has heard of sexually transmitted diseases						
Yes	98	98.00	99	99.00	0.9 [†]	0.041
No	2	2.00	1	1.00		
Knowledge about transmission of sexually transmitted diseases						
Yes	93	93.00	98	98.00	0.1 [†]	0.121
No	7	7.00	2	2.00		
Sources of information on the prevention of sexually transmitted diseases[‡]						
Websites in general	73	33.80	68	28.94	0.1* 0.150	
Conversations with friends	46	21.30	51	21.70		
Health services/professionals	40	18.52	61	25.96		
Scientific journals and books	20	9.26	31	13.19		
Magazines and books in general	11	5.09	10	4.25		
Television	18	8.33	9	3.83		
Newspapers	8	3.70	5	2.13		

*Pearson's Chi-Square Test. [†]Fisher's exact test. [‡]The total differs from the number of participants because respondents could select more than one option.

DISCUSSION

This study's results, obtained from a convenience sample and, therefore, not generalizable, describe contrasting patterns between heterosexual and homosexual young men in terms of sociodemographic characteristics, sexual behaviors, knowledge about STIs, and access to health services. Age composition constitutes a first crucial interpretative axis: there was a predominance of young adults among homosexual individuals and younger youth among heterosexual individuals, with mean ages of 25.93 and 23.57 years, respectively. The literature suggests that older age is often associated with higher levels of knowledge about STIs, although not universally. Studies with youth and university populations have indicated a cognitive advantage among individuals aged 25 to 30 years compared to those aged 15–24 years,^{10,11} whereas other investigations have not identified an effect of age.^{12,13} This apparent inconsistency reinforces that age, education, social context, and access to information interact in complex ways.¹² The higher proportion of ≥ 12 years of schooling among homosexual individuals aligns with evidence that higher education tends to be associated with greater knowledge and better practices,^{14,15} although higher levels of education do not guarantee adequate knowledge.^{11,16}

In the domain of sexual behaviors, a pattern emerges that is consistent with both international and national literature: inconsistent condom use among young people, with nuances according to type of partnership and sexual orientation. In this finding, homosexual individuals reported lower condom use at first sexual intercourse and lower use across all sexual encounters, in addition to more episodes involving multiple partners within the same period; on the other hand, heterosexual individuals reported lower adherence in casual partnerships, whereas homosexual individuals reported lower adherence in steady partnerships. These patterns are in line with evidence of a decline or maintenance at low levels of consistent condom use among young people.^{15,17} In addition to multicausal determinants, such as low risk perception, especially in steady relationships,¹⁸ alcohol and other drug use before/during sexual intercourse;¹⁹ gender pressures and norms of masculinity that valorize risk behaviors;⁵ discomfort and reduced pleasure attributed to condom use;²⁰ gaps in sexual education and negotiation skills;²¹ and substitution by fertility control, disregarding dual protection.¹⁵ Although part of the literature describes lower condom use among gay adolescents,²² Brazilian findings show higher use among homosexual young people in certain contexts.²³ This heterogeneity reinforces that relational norms (steady/casual), socialization contexts, and preventive resources modulate condom adherence differently across subgroups.

The number of sexual partners in the past 12 months – substantially higher among homosexual individuals in this sample – follows trends described in studies with men who have sex with men (MSM), which indicate an increase in the number of total partnerships and a reconfiguration between main and casual partnerships over time.²⁴ Studies with university students and sexual health services show varying averages depending on the context.^{25,26}

The use of apps and the higher proportion of single individuals may contribute to this pattern among homosexual individuals,²⁷ although differences in the number of partners do not, by themselves, imply lower condom use when other variables are considered.²⁸ Nevertheless, a higher number of partnerships constitutes a classic determinant of risk for STIs,²⁹ which requires harm reduction strategies proportional to the pattern of exposure.

In terms of access to services, the data indicated greater engagement of the homosexual group with the healthcare network: more frequent seeking of care, higher testing rates (HIV, syphilis, hepatitis), and more frequent reports of counseling. These findings are consistent with the historical prioritization of gay men and MSM as key populations in Brazilian HIV response policies and with the provision of combined prevention technologies (rapid testing, PEP, PrEP, vaccination) within the Unified Health System (*Sistema Único de Saúde* - SUS).^{4,30} At the same time, systematic reviews highlight persistent barriers – stigma, discrimination, and institutional heteronormativity – that undermine the quality of care and the continuity of preventive strategies.^{31,32} The international and national literature also shows significant variation in MSM testing, with very high coverage in some contexts and gaps in others,^{30,33,34} indicating contextual inequalities in access and missed opportunities for counseling.¹¹

Among heterosexual young men, the lower demand for services, lower testing rates, and fewer reports of counseling revealed important gaps in the coverage of preventive actions in this group. These results suggest that strategies based solely on spontaneous demand tend to reproduce invisibility, requiring the expansion of outreach actions conducted by Nursing in youth, sports, educational, and community settings. On the other hand, among homosexual young men, although greater linkage to services is observed, challenges related particularly to stigma and discrimination persist. In this sense, the data indicated that nurses occupy a strategic position in mediating information, longitudinal care, and the development of practical competencies for sexual health self-care, especially within the scope of combined prevention.

Regarding knowledge, the high self-reported familiarity with “STI” and “modes of transmission” in this sample should not be interpreted as adequate knowledge. Some studies reiterate that central contents (condom use, sexual transmission) are widely recognized, but misconceptions persist regarding asymptomatic presentation, vertical and parenteral transmission, and unfounded beliefs.^{11,35–37} The Internet emerges as the main source, followed by television, school/college, and health professionals. This centrality of the digital environment has a dual effect: it expands access but varies in quality and reliability, and does not always translate into protective practices.^{11,36,37} Hence the need for qualified educational interventions, especially in school and community settings, using inclusive language and focusing on skills (negotiation, correct condom use, harm reduction).^{11,35}

Socioracial findings also require attention. In this sample, heterosexual individuals more frequently identified as white, whereas homosexual individuals predominantly self-identified as black (including black and mixed-race). Although black individuals constitute the majority of the population in Brazil, structural racism imposes barriers to access, quality of care, and social opportunities, resulting in worse health outcomes.³⁸ In the case of black homosexual individuals, intersectionality highlights an accumulation of oppressions (racism + homophobia) with impacts on access to rights, social protection, and use of services.³⁹ These layers of vulnerability must be considered in the design of policies and interventions, as inequalities may be reproduced.

Differences in affective relationships, with a higher proportion of relationships among heterosexual individuals and a higher proportion of single individuals among homosexual individuals, can be interpreted in light of heteronormative norms and minority stress.⁴⁰ Heteronormativity facilitates the visibility and acceptance of heterosexual relationships in public and family spaces, whereas stigma and discrimination restrict opportunities for affective socialization among young individuals belonging to the population group of lesbians, gays, bisexuals, transsexuals, transgender people, transvestites, queer, intersex, asexual, pansexual, non-binary, and other minority groups (LGBTQIAPN+). These factors are not merely contextual: they affect condom negotiation, adherence to care, mental health, and support networks, shaping behaviors and vulnerabilities.²⁷

It should be reiterated that the results must be interpreted in light of the limitations inherent to the sampling design and the characteristics of the group composition itself. The convenience sampling, conducted in specific youth socialization settings, although diversified in terms of territories, days, and times, limits the generalization of findings to other urban and population contexts. Furthermore, the age differences observed between heterosexual and homosexual individuals, with a higher proportion of young adults in the latter group, may act as a confounding factor in some associations, since age is related to educational trajectories, sexual experiences, access to information, and linkage to health services. Thus, part of the differences attributed to sexual orientation may, at least in part, reflect distinct stages in the youth life course. The patterns described here express experiences situated in particular circuits of leisure and social interaction and cannot be extrapolated to all young people.

CONCLUSION AND IMPLICATIONS FOR THE PRACTICE

This study allowed for the comparison of sexual behaviors, knowledge about STIs, and access to health services among heterosexual and homosexual young men, highlighting both similarities and significant differences between the groups. Overall, it was identified that consistent condom use remains low in both groups, although with distinct nuances according to the type of partnership, and that homosexual young men presented

a higher average number of sexual partners. However, this group also demonstrated greater engagement with health services, undergoing more testing and seeking counseling from health professionals more frequently than heterosexual individuals. Regarding knowledge, although most participants reported familiarity with the term STI and with modes of transmission, this perception does not necessarily translate into in-depth and adequate knowledge, which points to the need for continuous and qualified educational interventions. Sociodemographic aspects, such as age, education, affective relationship status, and skin color, were associated with different dimensions of sexual and preventive practices, suggesting the influence of social markers in shaping vulnerabilities.

However, it is acknowledged that the use of a questionnaire without psychometric validation, the convenience sampling, and the distinct age composition between the groups impose limitations on causal inferences and the generalization of findings. Nevertheless, the results provide relevant contributions to understanding the vulnerabilities of young people in relation to STIs and reinforce the need for future investigations with probabilistic samples and more robust designs. Longitudinal studies may help clarify behavioral trajectories in the transition from younger youth to young adulthood, while mixed-method approaches have the potential to deepen the understanding of the meanings attributed to sexual practices and negotiations around risk in different socialization contexts.

It is concluded that vulnerabilities to STIs among young people are not restricted to individual choices, but are shaped by structural, relational, and cultural factors that affect heterosexual and homosexual individuals differently. These findings reinforce the importance of developing public policies and prevention strategies that consider sexual diversity and the specificities of different youth groups, valuing inclusive, educational, and equity-based approaches in health promotion. In this sense, the results support three priority areas for action: (1) comprehensive and inclusive sexual education, grounded in evidence, with emphasis on dual protection, correct and pleasurable condom use, harm reduction related to alcohol and drug use, and the development of negotiation skills; (2) expansion and qualification of care in health services, through stigma-free reception, proactive STI approaches during consultations, counseling opportunities linked to testing, and the systematic provision of combined prevention technologies; and (3) incorporation of an intersectional perspective into public policies, with actions that recognize and mitigate the effects of class, race/skin color, age, education, and sexual orientation, avoiding universalist solutions that tend to mask inequalities. In a context of rising conservatism and the weakening of prevention policies aimed at youth, it becomes imperative to emphasize the centrality of health education and access to quality information as fundamental strategies for addressing STIs.

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DATA AVAILABILITY RESEARCH

The data underlying the research text are contained in the article.

CONFLICT OF INTEREST

No conflict of interest.

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