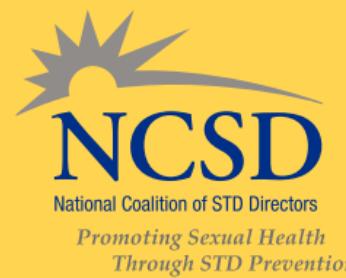


Providing Optimal Care for Your MSM Patients



Medical providers have a critical role to play in improving the health outcomes of Black and Latino men who have sex with men (BLMSM). Studies reinforce the significance of clinicians offering vaccines and recommending diagnostic STD testing.

In addition to providing vaccinations for patients, HIV/STD counseling and testing, and collecting more comprehensive sexual histories, providers can play a pivotal role in assisting gay, bisexual, and other MSM patients in developing greater knowledge of their sexual health needs.

Black and Latino MSM-Centered Care

Recent data underscores the need to do more to eliminate adverse sexual health outcomes among MSM – and particularly among MSM of color. In the report “Estimated HIV Incidence in the United States, 2006-2009,” researchers found that between 2006 and 2009 there was a 48 percent increase in new HIV infections (an increase of 12.2 percent annually) in young (ages 13-29) Black MSM.

In addition, recent HIV and STD incidence data from 27 states reported an increase in syphilis rates among Black and Latino MSM, which were up to eight times that of white MSM. The data highlight the need to address the role stigma plays in impeding patient-centered care for Black and Latino MSM.

Break through Stigma

A provider may be better able to deliver culturally appropriate care when he or she understands how racial bias and same-sex sexuality stigma may be associated with STD and HIV infection and act as barriers to appropriate diagnostic and treatment services for Black and Latino MSM. For instance, studies suggest that racial bias and same-sex stigma (or homophobia) impair the relationship between providers and MSM patients.

Some physicians’ “negative perceptions of African-Americans influence their expectations of these patients

to engage in risk behavior and follow medical advice.”^{7,8} Perceived race-based discrimination impacts the doctor-patient relationship, particularly when it comes to issues of medical utilization and adherence.⁷

Evidence suggests that same-sex stigma could be a contributing factor to the lack of sexual health discussions between Black and Latino MSM patients and providers. MSM of color are less likely than white MSM to identify as gay or disclose their same-sex desires or behaviors to others.^{9,10} Data suggest that patients often expect health care providers to initiate the sexual health discussion.^{11,12} Yet, providers rarely initiate conversations about HIV and STD risk.¹³ In this context, discussing STDs, such as Syphilis, Gonorrhea, viral hepatitis and HIV/AIDS with an MSM patient can be difficult but necessary.

In fact, discomfort with the discussion of sexual history may exist for both the provider and the MSM patient. Some physicians identify stigma-related barriers as the reason for not recommending HIV testing, such as the concern that a recommendation to test would be perceived as accusatory or judgmental by their patients.²

To Remove Stigma from the Conversation

- Emphasize that you ask every patient the same questions
- Assure patient of confidentiality
- Make NO assumptions about sexual practices or identities



Case for Sexual History Taking

Part of any patient-provider consultation involves the provider asking questions to better assess the needs of his or her patient. Yet some clinicians do not take sexual histories or ask questions that capture sexual behaviors. In fact, only 27 percent of surveyed primary care physicians ask their patients about their sexual orientation.¹³

While this direct question on sexual orientation may capture gay self-identifying MSM, studies show that some MSM, particularly MSM of color, may not identify as gay or bisexual, and that as a result, providers who rely solely on a patient's self-reported sexual orientation/identity may not accurately assess their patient's risk for STDs and HIV.¹⁰

Therefore, taking a sexual history of each male patient may allow for a better assessment of a patient's risk factors and may better inform the types of sexual health services that should be provided to a patient.

Samples of sexual history questionnaires can be found here:

1. California Department of Health
www.stdcheckup.org
2. Centers for Disease Control and Prevention and the Department of Health and Human Services
www.cdc.gov/std/treatment/sexualhistory.pdf

Taking a sexual history allows providers to:

- Identify individuals at risk
- Screen appropriate anatomical sites
- Provide appropriate risk reduction counseling to prevent future exposure to STDs/HIV

The 4 “P”s Standard

As a general rule, taking a sexual health history can be an easier process for providers and their patients by following the 4 “P”s:

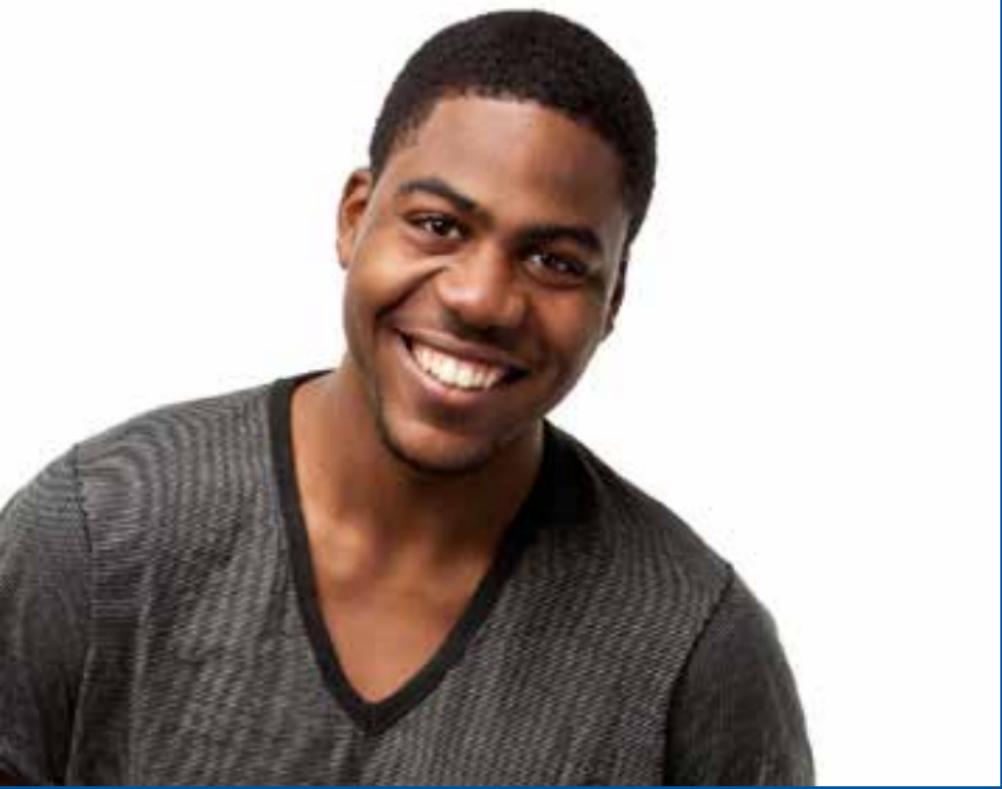
- P**artners
- P**ractices
- P**ast history of STDs
- P**rotection from STDs

Sample questions that follow the 4 “P”s include:

- Are you currently sexually active? Are you having sex? (**Partners**)
- In recent months, how many sex partners have you had? (**Partners**)
- Are your sex partners; women, men, both, transgender persons or all of the above? (**Partners**)
- Do you have oral sex? Are you the oral receptive or insertive partner? (**Practices**)
- Do you have anal sex? Are you the anal receptive or insertive partner? (**Practices**)
- Do you or have you ever shared any needles? (**Practices**)
- Do you get tested for STDs including HIV? When you get tested for STDs have you ever had a rectal or pharyngeal (oral) swab? (**Practices**)
- Have you or your partner ever had a STD before? If so, which one(s) and where was the infection found? (**Past history**)
- Were you treated? Did you have a follow up with your doctor after treatment? (**Past history**)
- How often do you use condoms or other barrier methods for vaginal, anal and oral sex? (**Protection**)

During the sexual history taking, a patient may disclose a history or a recent occurrence of sexual abuse, domestic/intimate partner violence, or mental health issues. As a clinician, even if not with an in-house staff





person, it is important to be able to refer patients to the appropriate place for care if such disclosure is made. If the disclosed occurrence is very recent providers may also suggest STD testing and possibly Post Exposure Prophylaxis (PEP). Please see page eight of this brochure for additional information on PEP.

Screen for STDs and HIV

The Centers for Disease Control and Prevention (CDC) recommends that sexually active gay, bisexual and other MSM should be annually screened for common STDs:

- Chlamydia
- Gonorrhea
- Syphilis
- HIV

The CDC recommends screening every three to six months for MSM at highest risk (i.e., MSM who use illicit drugs, and/or have multiple sexual partners). Based on what is learned from the sexual history, screening tests may involve other STDs.

The full CDC guidelines for MSM can be found here: www.cdc.gov/std/treatment/2010/specialpops.htm#msm

In addition to urine-based tests for Gonorrhea and Chlamydia, studies reinforce that a special emphasis should be placed on rectal and pharyngeal screening

for Gonorrhea and rectal screening for Chlamydia for those MSM patients with confirmed risk behaviors.^{16,17,18} Infections in these sites may often be asymptomatic and, if left untreated, may be a contributing factor to HIV acquisition and further spread of the diseases.

The CDC recommends that persons treated for Gonorrhea or Chlamydia receive follow-up rescreening three months after treatment due to the increased rate of Gonorrhea and Chlamydia repeat infections.

MSM-Tailored Screenings Matter

Patients listen to their health care providers. In fact, research has found that what made the difference in whether or not a client tested for HIV was if their provider suggested a test to them.² Unfortunately, data and some studies suggest that providers:

- Are not routinely recommending HIV and STD testing
- Are not screening non-genital sites (i.e., rectal and pharyngeal)

HIV and STD testing may be dependent on providers' suggesting it to their MSM patients. This presents an opportunity for providers to follow CDC recommendations of taking a sexual history, and offering STD testing at non-genital sites to their MSM patient.





Vaccinations for MSM

Beyond HIV and STD testing, MSM patients should be strongly encouraged to protect their sexual health by taking advantage of vaccines.

The 2010 CDC STD Treatment guidelines recommends that all MSM should be vaccinated for Hepatitis A and B.

These same 2010 CDC guidelines also notes that providers can **consider** Human Papillomavirus (HPV) vaccination for boys age nine up to young men age 26.

When considering if HPV immunization is right for a MSM patient a provider should consider the following:

- The risk of developing anal cancer is 17 times higher in gay or bisexual men than in heterosexual men²¹
- HPV is an independent risk factor for HIV infection²¹
- HPV is associated with approximately 90 percent of anal cancer²²

Post Exposure Prophylaxis (PEP)

PEP is a newer tool that providers can use to prevent the potential HIV sero-conversion of a patient. According to the CDC, PEP includes a basic

4-week regimen of two drugs (zidovudine [ZDV] and lamivudine [3TC], 3TC and stavudine [d4T], or didanosine [ddI] and d4T) for most HIV exposures and an expanded regimen that includes the addition of a third drug for HIV exposures that pose an increased risk for transmission. For more information, please consult the following two CDC resources:

1. Centers for Disease Control and Prevention 2005:
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5402a1.htm>
2. Centers for Disease Control and Prevention, 2001:
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm>

Pre-exposure prophylaxis (PrEP)

Prior to the U.S. Food and Drug Administration's (FDA) approval of pre-exposure prophylaxis (PrEP) among sexually active adults at risk for HIV infection, CDC issued an interim guidance to help inform clinical practice. CDC underscores the importance of targeting PrEP to MSM at high-risk for HIV acquisition and delivering it as a part of comprehensive HIV prevention services, which should include risk-reduction and medication adherence counseling, condoms, and testing and treatment for other sexually-transmitted infections. The guidance stresses the need to ensure any MSM who may be prescribed PrEP are





confirmed to be HIV negative prior to use, as well as the need for regular monitoring of HIV status, side effects, adherence, and risk behavior among those taking PrEP. For more information, please refer to CDC's resource: Interim Guidance: Pre-exposure Prophylaxis for the Prevention of HIV Infection in Men Who Have Sex with Men at: <http://www.cdc.gov/mmwr/pdf/wk/mm6003.pdf>

Care for HIV-Positive MSM

In some ways, providing care to HIV-positive MSM mirrors the services and patient-centered care offered to HIV-negative MSM. In other ways, particularly around issues of adherence to HIV medication and depression, HIV-positive MSM face additional sexual health challenges.

There are distinct concerns regarding STDs and routine screenings that can be considered for HIV positive individuals. For example, co-infections are common and present challenges to providing care for HIV positive clients (e.g., Hepatitis C, Syphilis, and HPV related Anal Cancer²¹).

Clinicians who manage the health of HIV positive MSM should routinely screen their patients for:

- **Chlamydia (urine-based test, urethral and rectal swabs)**
- **Gonorrhea (urine-based test, urethral, rectal**

and pharyngeal swabs)

- **Syphilis**

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For additional information, please contact NCSD (www.ncsddc.org) and NASTAD (www.nastad.org).

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