

# MSM SEXUAL HEALTH STANDARDS OF CARE

**Addressing the Sexual Health Crisis among Gay, Bisexual and other  
Men who have Sex with Men (MSM)**

**October 26, 2017**

# EXECUTIVE SUMMARY

- The National Coalition of STD Directors (NCSD) and the National Alliance of State and Territorial AIDS Directors (NASTAD) convened a Blue Ribbon Panel of experts from academia, city and state health departments, the Centers for Disease Control and Prevention (CDC), and the National Network of STD/HIV Prevention Training Centers (NNPTC) to develop optimal standards of client-focused clinical care for **gay, bisexual, and other men who have sex with men (MSM)**.
  - March 19-20, 2015
- These standards illustrate the highest quality of sexual health care for MSM, expanding beyond federal guidelines to incorporate the collective experience of experts in the field of sexual health.
  - August 18, 2017

# WHO ARE THEY?

- **NCSD** is a partnership of public health professionals dedicated to advancing effective STD prevention programs and services in every community across the country. NCSD does this as the voice of their membership. NCSD provides leadership, builds capacity, convenes partners, and advocates.
- **NASTAD** is a leading non-partisan non-profit association that represents public health officials who administer HIV and hepatitis programs in the U.S. and around the world. Its mission is to end the intersecting epidemics of HIV, viral hepatitis, and related conditions.
- **NNPTC** is a CDC-funded group of training centers created in partnership with health departments and universities. The PTCs are dedicated to increasing the knowledge and skills of health professionals in the areas of sexual health.

# WHO AM I?

- Medical Epidemiologist with the Division of STD Prevention (DSTDP) at the Centers for Disease Control & Prevention (CDC)
  - Subject Matter Expert on LGBT health and extragenital STD screening of MSM
- Embedded within the Washington, DC Department of Health since 2002
- Currently act as the STD Medical Epidemiologist with the Strategic Information Division (SID) at the HIV/AIDS, Hepatitis, STD & TB Administration (HAHSTA)
- Volunteer physician at Whitman-Walker Health's **Gay Men's Health & Wellness Clinics**
- Member, **Gay Men's Health Equity Workgroup**
- Member, **Blue Ribbon Panel** of experts

SEXUAL HEALTH CRISIS FOR GAY,  
BISEXUAL, AND OTHER MEN WHO  
HAVE SEX WITH MEN (MSM)

# PUBLIC HEALTH IMPACT

- **The incidence of many STDs in MSM – including primary and secondary (P&S) syphilis and antimicrobial-resistant gonorrhea – is greater than that reported in women and men who have sex with women only (MSW).**
- **In addition to the negative effects of untreated STDs, elevated STD burden is of concern because it may indicate high risk for subsequent HIV infection.**
- **Annual increases in reported STD cases could reflect increased frequency of behaviors that transmit both STDs and HIV (e.g., condomless anal sex), and having an STD increases the risk of acquisition or transmission of HIV.**

# POSSIBLE REASONS

- The relatively high incidence of STD infection among MSM may be related to multiple factors, including individual behaviors and sexual network characteristics.
- The number of lifetime or recent sex partners, rate of partner exchange, and frequency of condomless sex each influence an individual's probability of exposure to STDs.
- However, MSM network characteristics such as high prevalence of STDs, interconnectedness and concurrency of sex partners, and possibly limited access to health care also affect the risk of acquiring an STD.
- Furthermore, experiences of stigma – verbal harassment, discrimination, or physical assault based on attraction to men – are associated with increased sexual risk behavior among MSM.

# DISPARITIES WITHIN THE DISPARATE

- Disparities among MSM reflect those observed in the general population, with disproportionate incidence of STDs reported among racial and ethnic minority MSM, MSM of lower socioeconomic status, and young MSM.
- The higher burden of STDs among MSM with these characteristics, relative to the general population of MSM, may suggest distinct mixing patterns in their sexual networks, reduced access to screening and treatment, and differential experiences of stigma and discrimination, rather than greater numbers of sexual partners or frequency of condomless sex.
- Disparities may also be more pronounced for racial and ethnic minority MSM who are also unemployed, young, and/or of lower socioeconomic status.



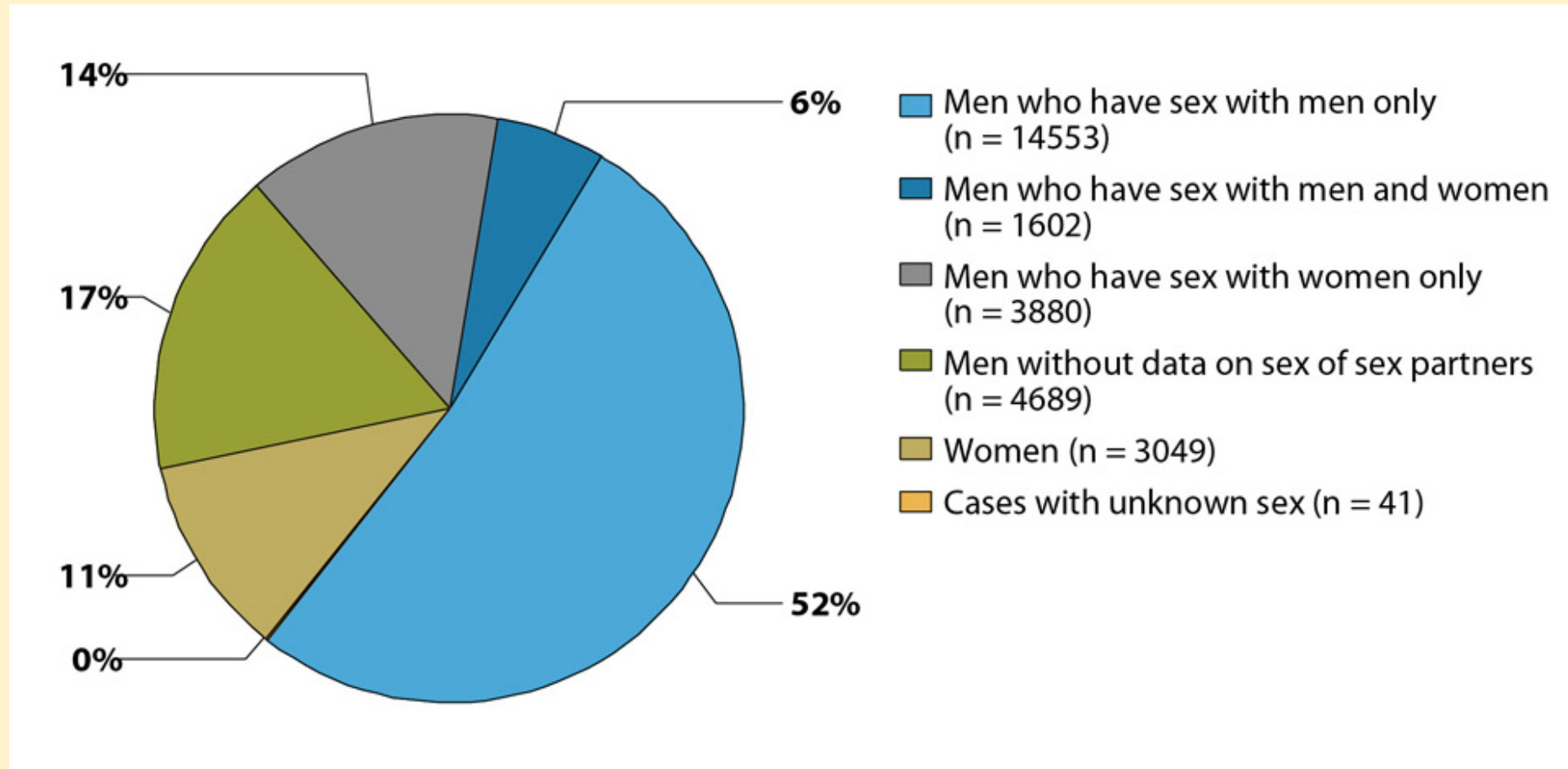
# NATIONAL SURVEILLANCE DATA

- **With the exception of reported syphilis cases, nationally notifiable STD surveillance data do not routinely include information on sexual behaviors and these data are missing for the majority of gonorrhea and chlamydia cases reported to CDC.**
- **Therefore, trends in STDs among MSM in the United States are based on findings from sentinel and enhanced surveillance systems.**
- **Testing strategies are also evolving to include more extragenital STD screening, which may increase detection of asymptomatic infections.**
- **Until recently, testing for gonorrhea and chlamydia in MSM largely focused on detecting urethral infections, which are more likely to be symptomatic than pharyngeal or rectal infections.**

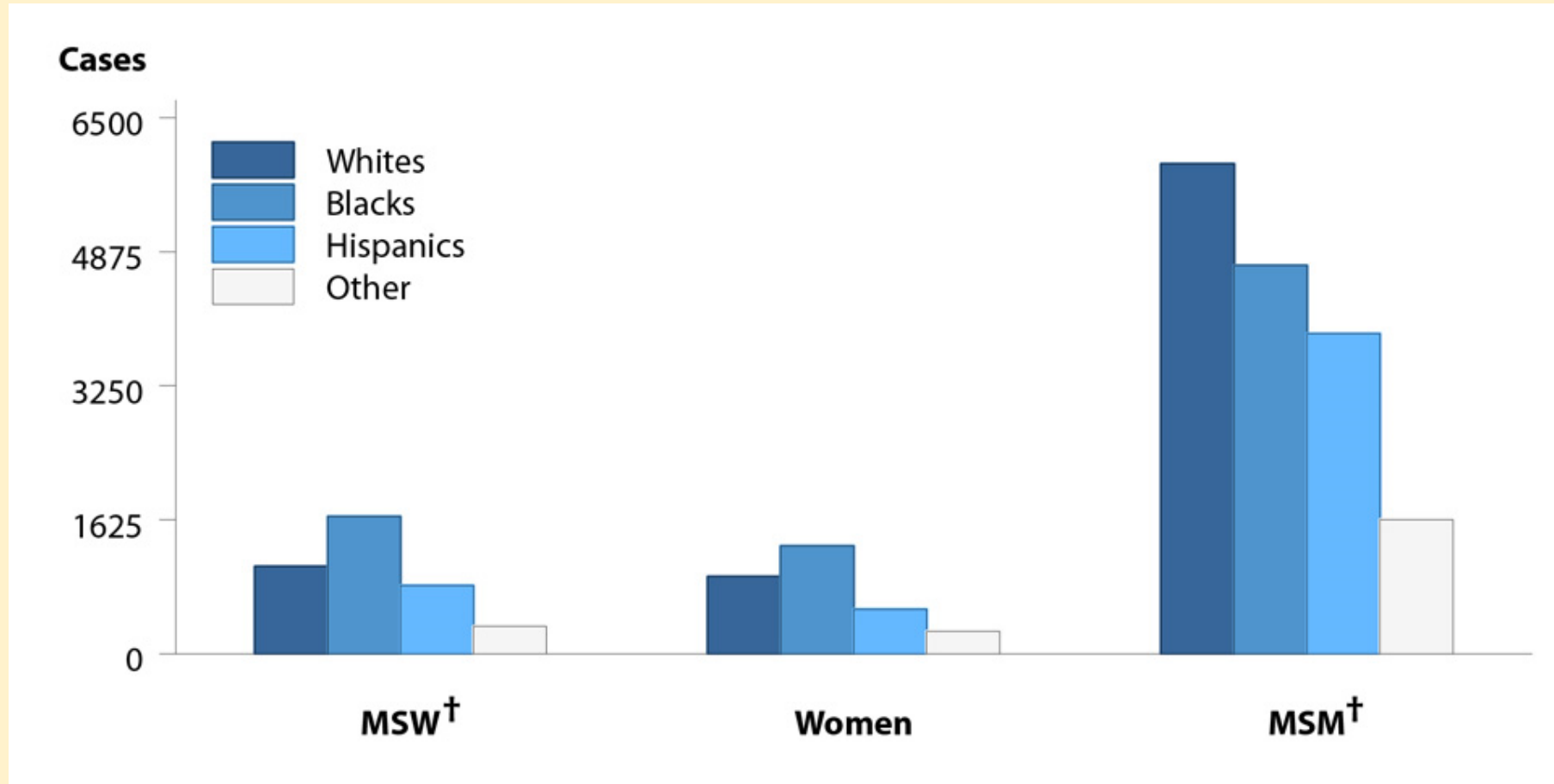
# SUPPLEMENTAL SOURCES

- For data reported in the following twelve slides, MSM were defined as men who either reported having one or more male sex partners or who self-reported as gay/ homosexual or bisexual.
- MSW were defined as men who reported having sex with women only or who did not report the sex of their sex partner, but reported that they considered themselves straight/heterosexual.
- Data presented in this chapter are derived from the **National Notifiable Diseases Surveillance System** (NNDSS), the **Gonococcal Isolate Surveillance Project** (GISP), and the **STD Surveillance Network** (SSuN), a sentinel and enhanced surveillance project established in 2005 to provide supplemental information on STDs.

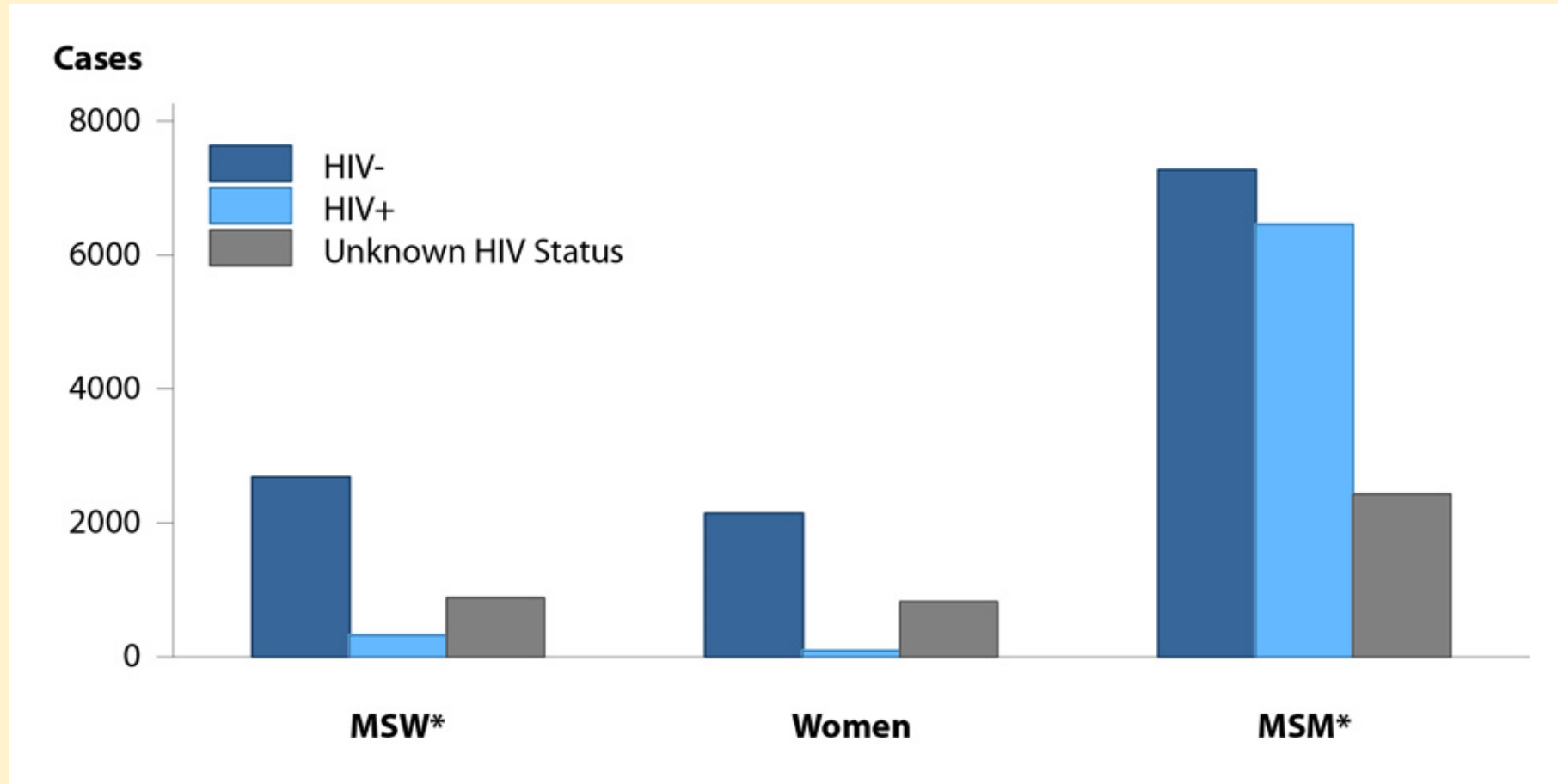
# Primary and Secondary Syphilis — Distribution of Cases by Sex and Sexual Behavior, 2016



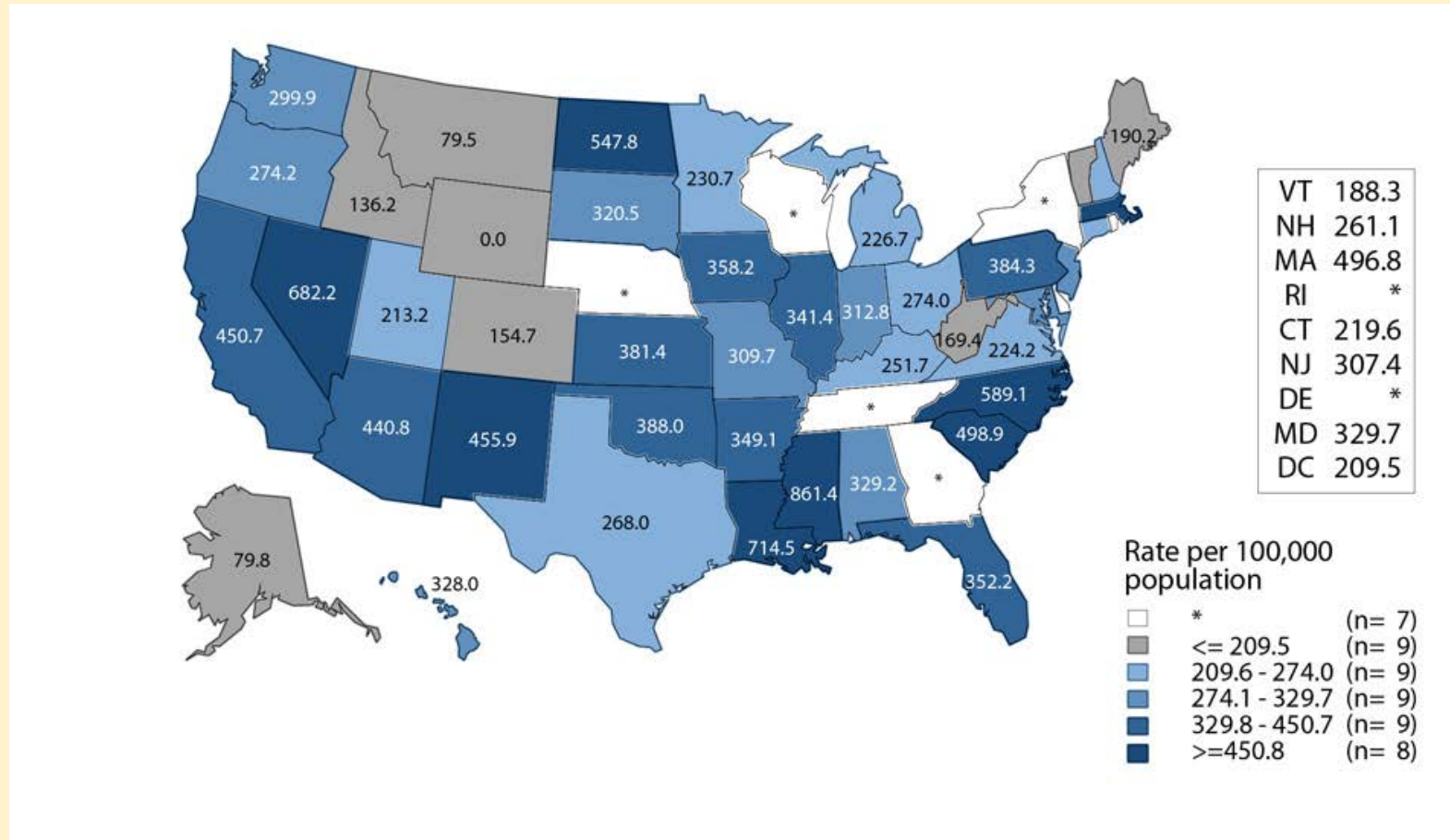
# PRIMARY AND SECONDARY SYPHILIS — REPORTED CASES BY SEX, SEXUAL BEHAVIOR, AND RACE/ETHNICITY, UNITED STATES, 2016



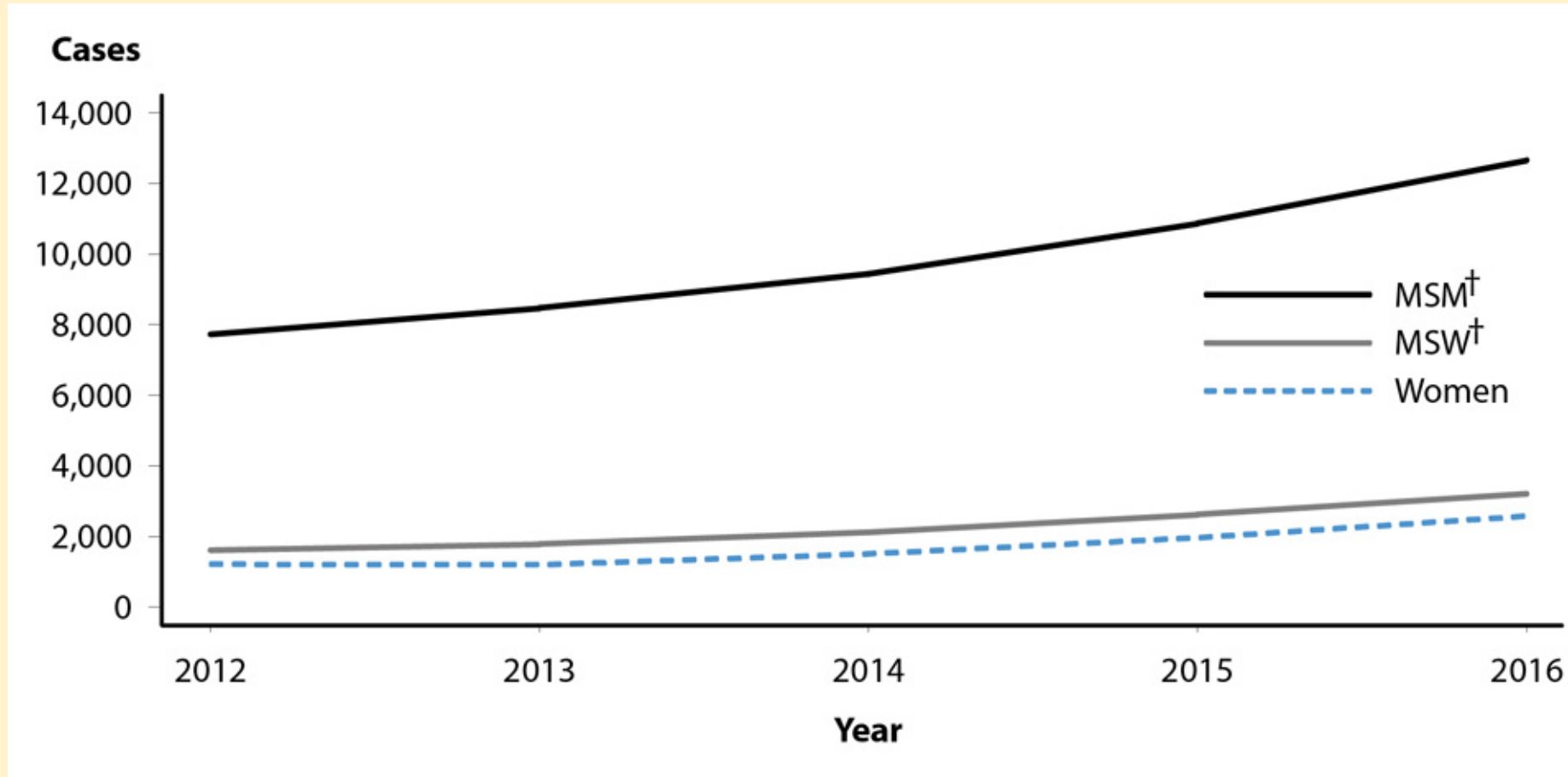
# Primary and Secondary Syphilis — Reported Cases by Sex, Sexual Behavior, and HIV Status, 2016



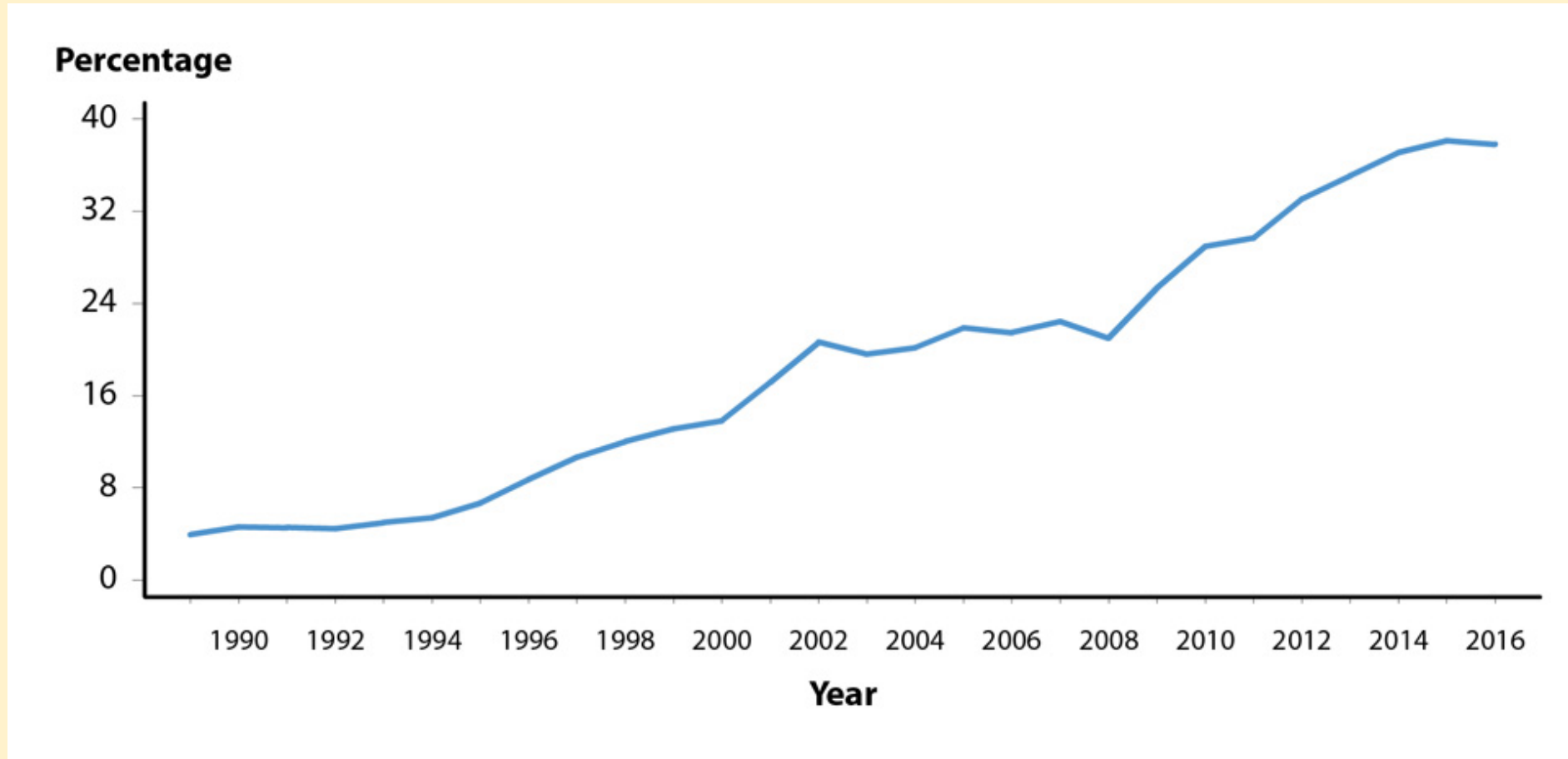
# Primary and Secondary Syphilis — Estimated Rates of Reported Cases Among MSM by State, United States, 2016



# Primary and Secondary Syphilis — Reported Cases by Sex and Sexual Behavior, 36 States\*, 2012–2016

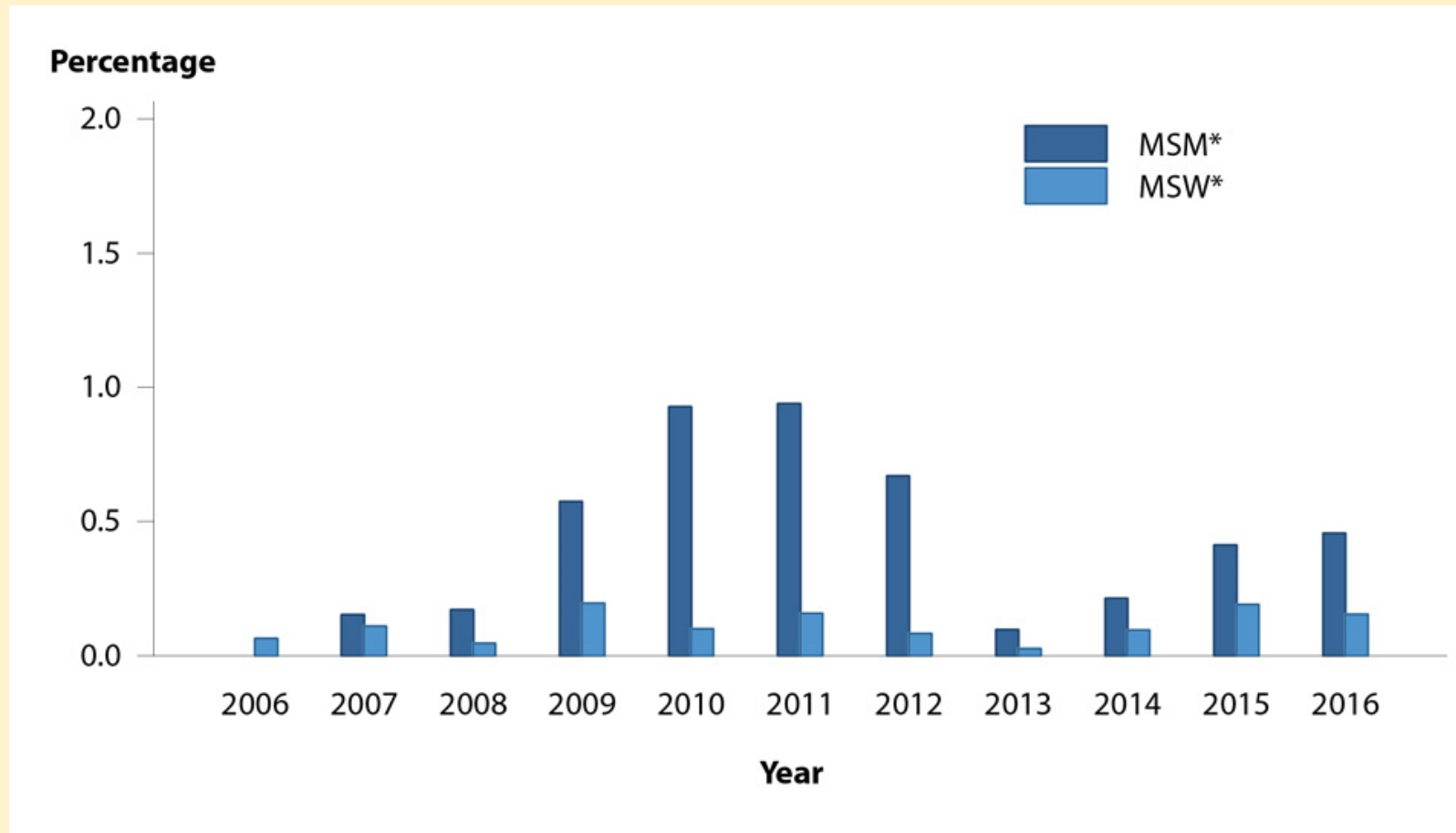


*NEISSERIA GONORRHOEAE* — PERCENTAGE OF URETHRAL ISOLATES  
OBTAINED FROM MSM ATTENDING STD CLINICS, GISP, 1989–2016

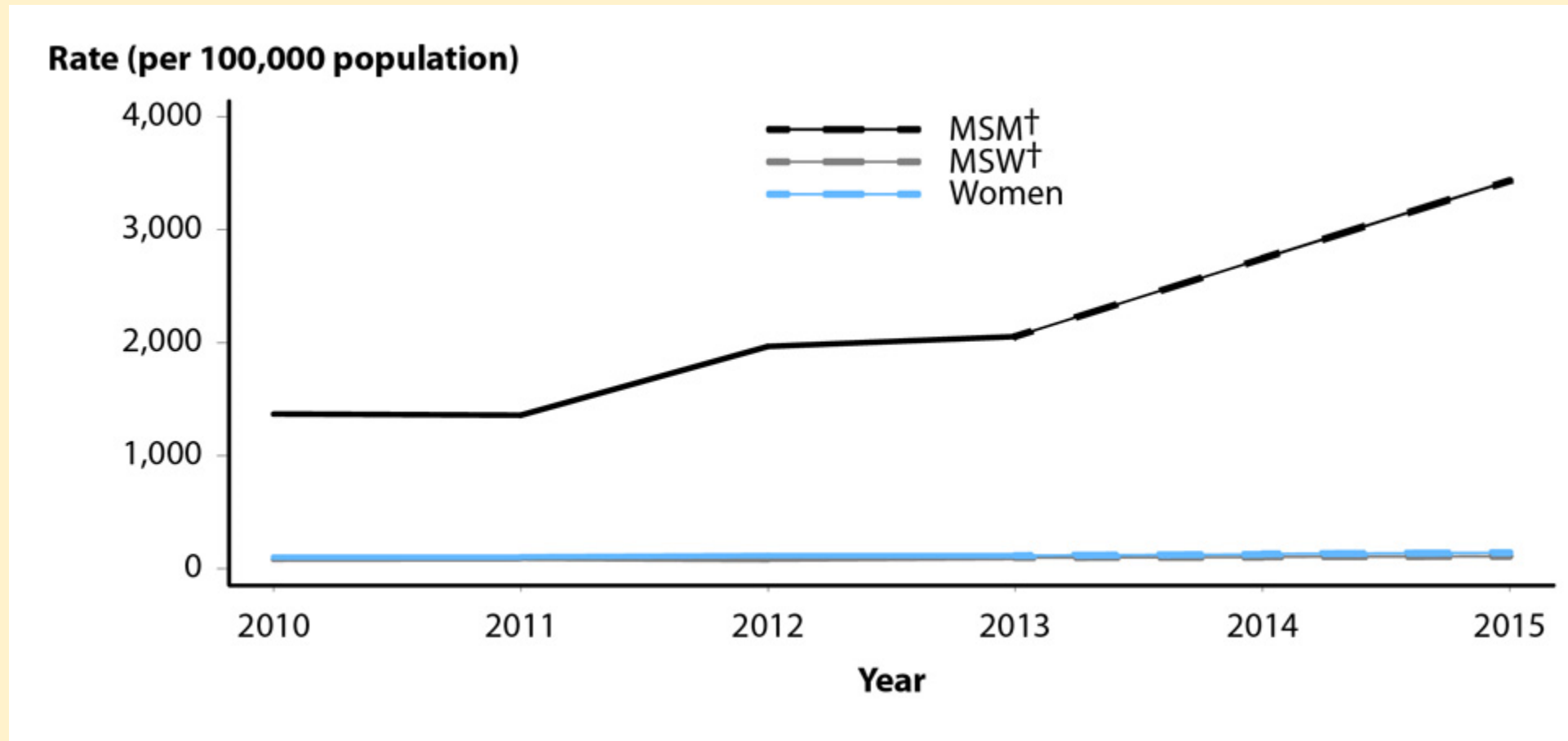




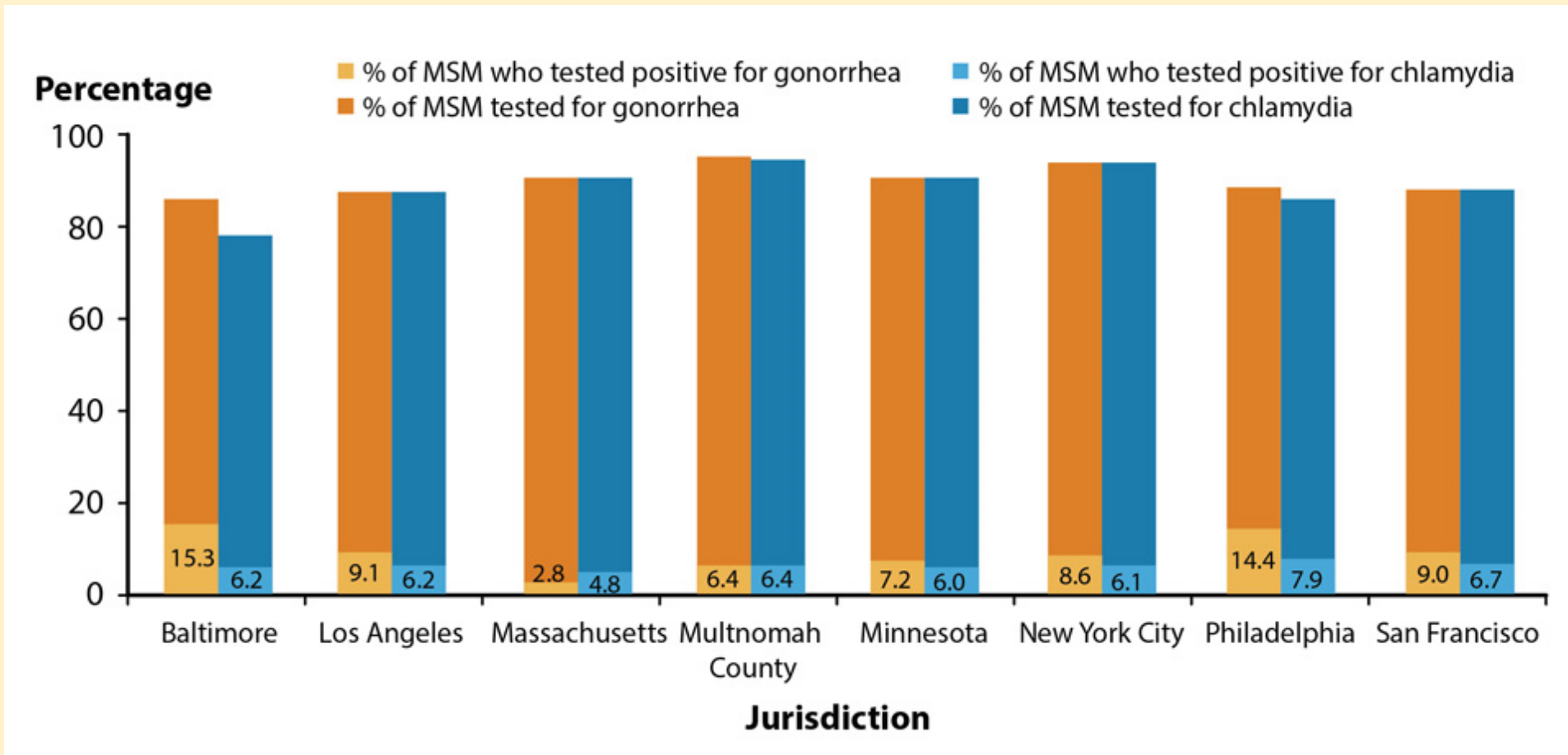
# *Neisseria gonorrhoeae* — Percentage of Urethral Isolates with Elevated Ceftriaxone Minimum Inhibitory Concentrations (MICs) ( $\geq 0.125$ $\mu\text{g/ml}$ ) by Reported Sex of Sex Partner, GISP, 2006–2016



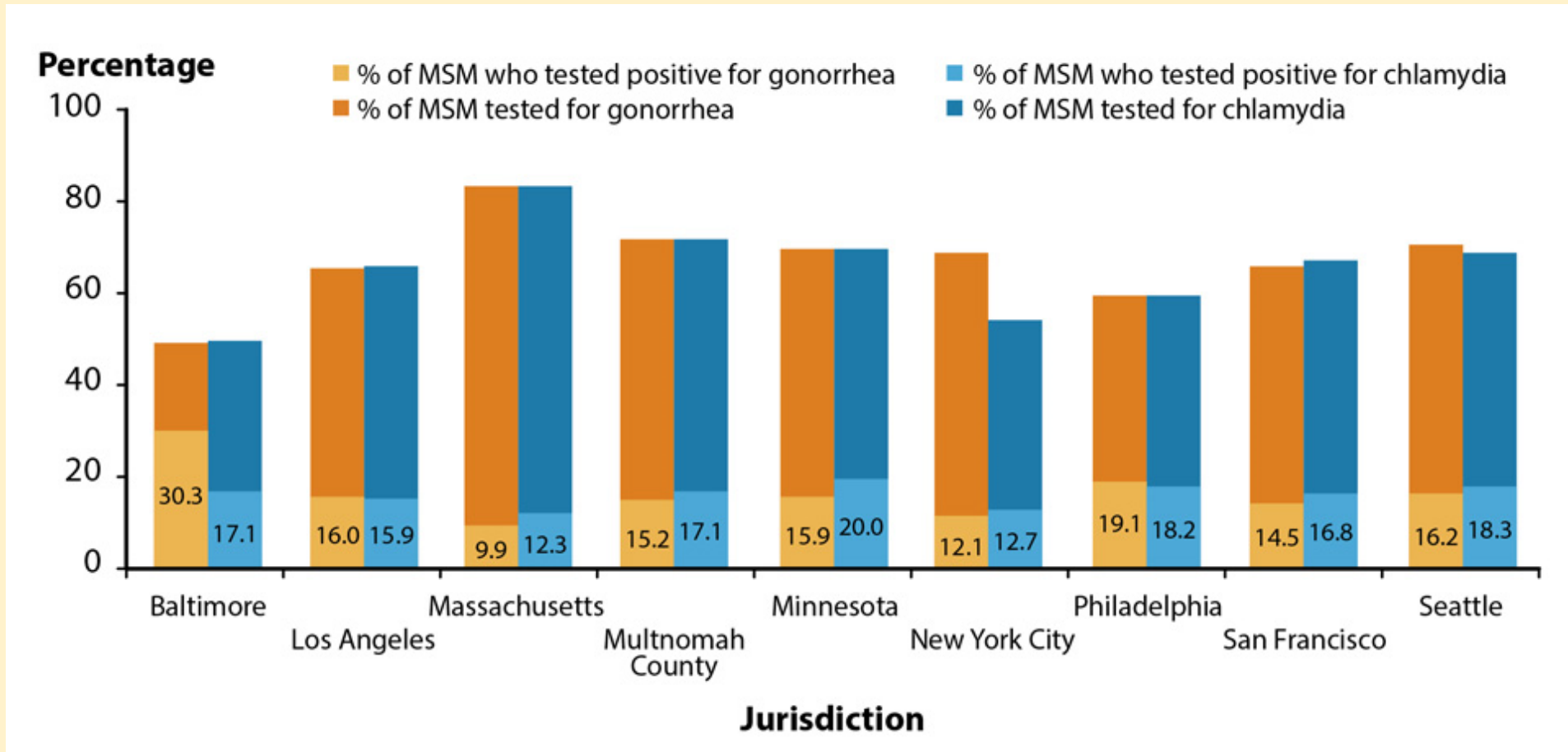
# Gonorrhea — Estimated Rates of Reported Gonorrhea Cases by MSM, MSW, and Women, STD Surveillance Network (SSuN), 2010–2015



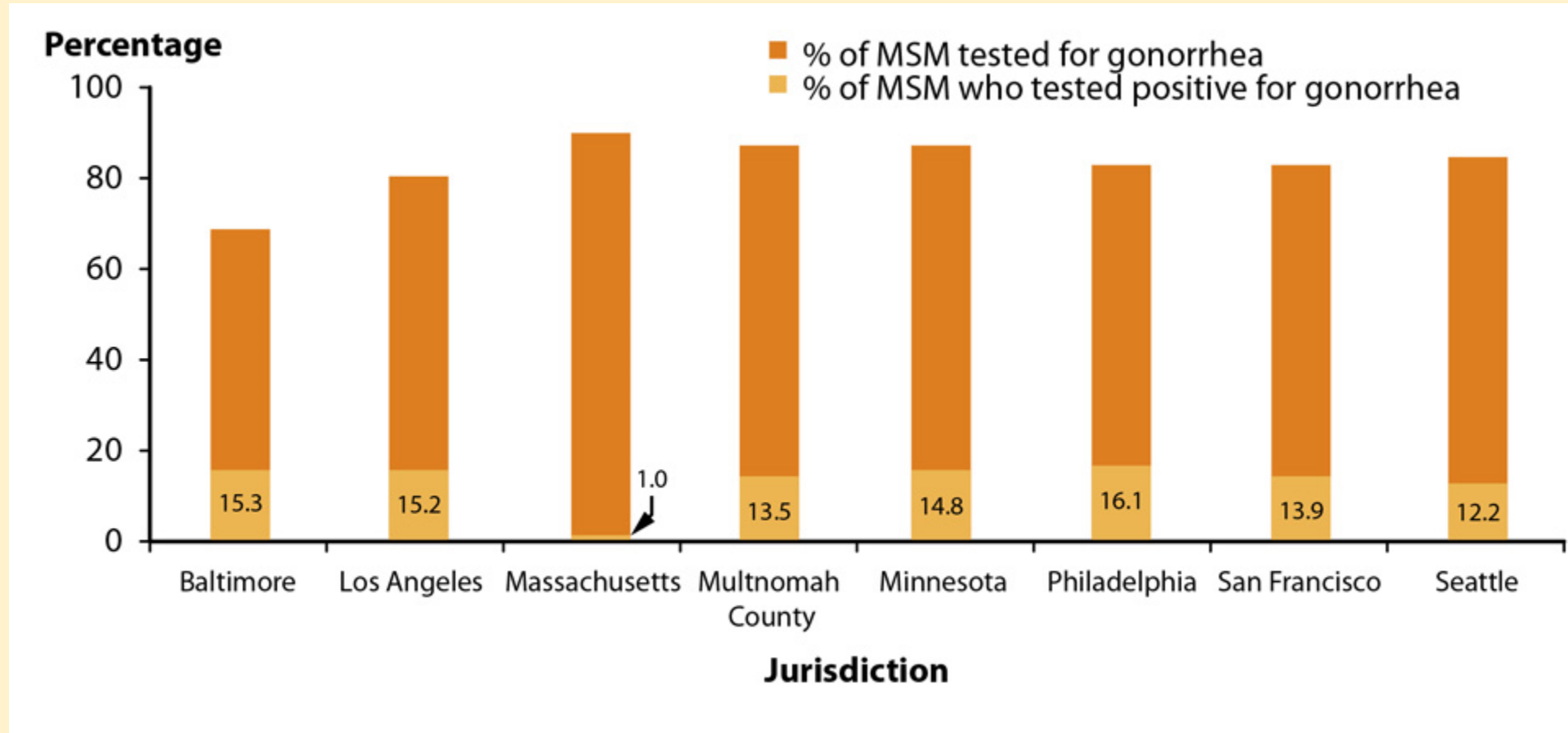
# Gonorrhea and Chlamydia — Proportion of MSM Attending STD Clinics Testing Positive for Urogenital Gonorrhea and Chlamydia by Jurisdiction, SSuN, 2016



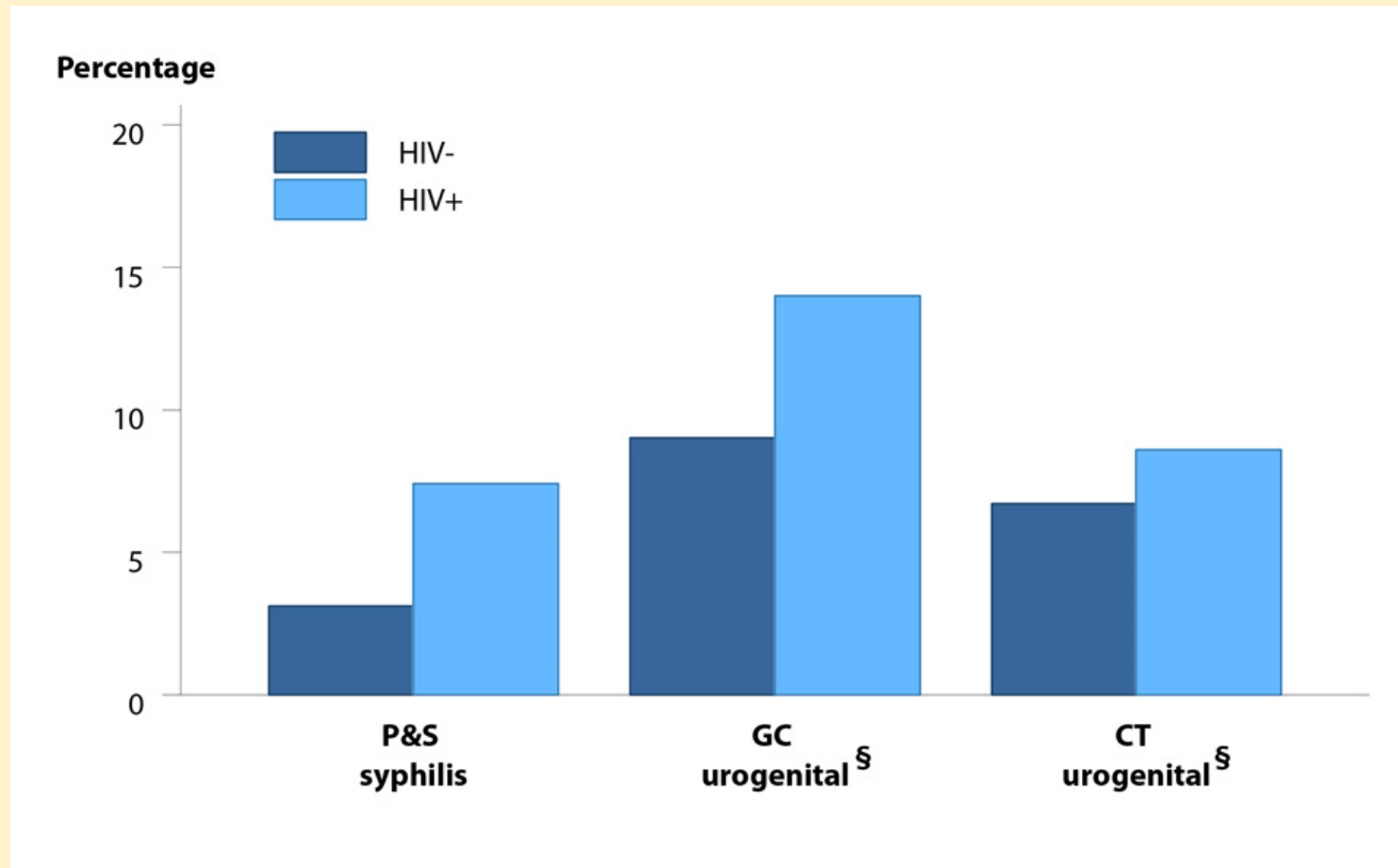
# Gonorrhea and Chlamydia — Proportion of MSM Attending STD Clinics Testing Positive for Rectal Gonorrhea and Chlamydia by Jurisdiction, SSuN, 2016



# Gonorrhea — Proportion of MSM Attending STD Clinics Testing Positive for Oropharyngeal Gonorrhea by Jurisdiction, SSuN, 2016



# Proportion of MSM Attending STD Clinics with Primary and Secondary Syphilis, Urogenital Gonorrhea, or Urogenital Chlamydia by HIV Status, STD Surveillance Network (SSuN), 2016



# SUMMARY

- The number of reported P&S syphilis cases among MSM continued to rise in 2016 and the majority of P&S syphilis cases remained among MSM.
- Estimated rates of reported gonorrhea incidence increased among MSM in SSuN jurisdictions in recent years.
- Furthermore, the proportion of GISP isolates with elevated MICs to antimicrobials currently used to treat gonorrhea was higher among MSM than among MSW.
- Beyond STD burden in the general MSM population, the data indicated heterogeneity of STD prevalence among MSM according to geography, race and ethnicity, and HIV status.
- State-specific P&S syphilis rate estimates among MSM varied from 0 to over 800 cases per 100,000 MSM and the prevalence of diagnosed STDs among MSM differed by SSuN jurisdiction.
- Reported P&S syphilis was disproportionately prevalent among Black and Hispanic MSM, and data from MSM who attended SSuN clinics suggested that P&S syphilis, urogenital gonorrhea, and urogenital chlamydia may be more prevalent among MSM living with diagnosed HIV infection than among HIV-negative MSM.

# MSM SEXUAL HEALTH STANDARDS OF CARE



# MSM SEXUAL HEALTH STANDARDS OF CARE

- Equip providers and health departments with tools for high-quality, culturally competent, LGBT-affirming care that is derived from a menu of options based on the whole person.
- A natural progression from materials developed by NCSD and NASTAD:
  - *Providing Optimal Care for Your MSM Patients*
  - *For Men Only: Your Sexual Health*
  - *The toolkit Addressing Stigma: A Blueprint for Improving HIV/STD Prevention and Care Outcomes for Black and Latino Gay Men*
- Come from a wealth of clinical and programmatic experience including pleasure in the sexual health discourse.
- Tackle the disease burden disproportionately faced by MSM.
- Can also be used to educate communities to empower MSM to demand the care they need and equip them with the knowledge of the quality sexual health care they deserve.

# GOALS AND OBJECTIVES OF THE BLUE RIBBON PANEL

- **Core goal = to develop optimal standards of client-focused clinical care and communication for gay, bisexual, and other MSM**
- **Objectives:**
  - **Convene a strategic consultation of experts to work toward developing a consensus on MSM sexual health needs.**
  - **Foster shared understanding among interested partners in STD/HIV prevention about MSM sexual health standard of care.**
  - **Develop, publish, and disseminate a shared standard of care or package of services for MSM.**

# SOCIAL DETERMINANTS OF HEALTH

- Significant evidence that social factors, such as racism, homophobia, immigration status, unemployment, mass incarceration, and homelessness are associated with poor health outcomes, even when controlling for other factors.
- These social determinants of health often intersect among gay, bisexual and other MSM, diminishing quality of life and creating barriers to sexual health along the spectrum of health care, including knowledge of the need for access:
  - The unemployment rate for Black men is 10.4 percent, and for Latino men 6.6 percent. Unemployment reduces access to quality health insurance for those individuals and their families.
  - The mass incarceration of Black and Latino men, who comprise 58 percent of all prisoners despite making up only 25 percent of the population, disrupts social and sexual networks in communities.
- The effects of these social factors compound and can manifest in higher rates of disease in specific communities.
- **Stigma**, along with other social determinants of health, is an unmeasured factor that impacts the acquisition of HIV and STDs and has repercussions all along the HIV care continuum.

# STIGMA

- **An indicator that negatively marks a person or group for a specific characteristic or behavior, is another barrier to optimal care for MSM.**
- **Influences both patient and provider comfort with discussing sexual practices and risk behaviors, and exposure to stigma in communities or in the medical system can create discomfort or fear about disclosing sexual orientation or sexual practices to health care professionals.**
  - **Nearly 40 percent of MSM do not share their sexual orientation with medical providers and many expect health care providers to initiate sexual health discussions.**
  - **Only 25 percent of patients receiving care in Ryan White clinics report that they discuss HIV transmission prevention with their providers.**
  - **Only six percent of patients diagnosed with HIV report discussing sexual practices with their primary providers.**
- **Some physicians identify stigma-related barriers as the reason for not recommending HIV testing, as they are concerned that a recommendation to test would be perceived as accusatory or judgmental.**
- **It is critical that health care providers recognize the role that stigma may play in their own perceptions of their patients when taking sexual histories, and ensure that assumptions about individual patient risk are not being made.**

# CULTURALLY COMPETENT SEXUAL HISTORY-TAKING

- To bring MSM sexual health standards to scale, providers must talk to all of their patients about sex, including questions about sexual orientation, gender identity, and sexual practices, to guide appropriate STD screening.
- Providers should build relationships with their patients to put them at ease and reduce barriers to open lines of communication.
- Quality sexual history-taking is client-centered, enforces strategies that patients are already using to maintain sexual health, and provides insight or information about other strategies that may work for patients.
- If providers are unaware that their male patients are having sex with men, they will not be equipped to address their sexual health care.
- Yet even well-intentioned physicians may not have these conversations with their patients.
- The CDC recommends using the Five Ps (**Partners, Practices, Past history of STDs, Protection, and Pregnancy**) as the foundation for sexual history-taking.
- The Blue Ribbon Panel extends this approach to include a sixth P: **Pleasure**.
- Sexual health should not be limited to risk management but tailored to each individual's needs, including talking to patients about pleasure and sexual satisfaction.

# EDUCATION AND COUNSELING: CONDOMS, LUBRICANT, AND DOUCHING

- **Discuss current condom use practices.**
  - Recommend latex, polyurethane, or polyisoprene condoms to prevent HIV and STD transmission.
  - “Natural” condoms (made of animal skin) are not effective for preventing STD and HIV transmission.
  - Have free condoms available in the office, waiting area, and restrooms.
  - Condom distribution programs are effective for reducing STDs, including HIV.
- **Educate patients about use of the “female” or insertive condom for receptive anal intercourse.**
  - This condom can be safely inserted into the rectum and is an alternative to the traditional male condom that may be preferred by some patients.
- **Discuss use of water- or silicone-based lubricants that do not include nonoxynol-9.**
  - Lubricant can increase comfort and pleasure, and reduce micro-tears in the anus.
- **Educate patients about increased risk of HIV acquisition with rectal douching and discuss safe rectal douching practices for patients who like to use douches or enemas.**
  - Less frequency of enemas is recommended.
  - When performed, warm water is strongly suggested.
  - Polyethylene glycol suppositories or enemas may be least irritating.

# EDUCATION AND COUNSELING: MENTAL HEALTH, SUBSTANCE USE, AND SAFETY

- **Screen for mental health and substance use concerns, as these impact all other aspects of health care and prevention.**
  - **Refer patients to MSM-affirming and harm-reduction resources within their communities.**
- **Screen for common conditions like depression, anxiety, and post-traumatic stress disorder.**
- **Consider discussing/screening for sexual addiction if patient reports what they would consider high activity.**
  - **Be mindful of the stigma of queer sexuality being considered oversexualized and how a sexual addiction diagnosis can be perceived by a patient.**
- **Screen for history of sexual abuse/violence and intimate partner violence.**
  - **Refer patients to MSM-affirming resources within their communities.**

# CLINICAL ASSESSMENT AND TESTING: CHLAMYDIA AND GONORRHEA SCREENING

- Screen patients for urethral, rectal, and pharyngeal chlamydia and gonorrhea at least annually.
- For patients with increased potential exposure to STDs, recommend more frequent screening (three to six months).
- Nucleic Acid Amplification Tests (NAATs) should be used wherever available for chlamydia and gonorrhea testing.
- Screen for rectal and pharyngeal gonorrhea and chlamydia using clinician or self-collected swabs.
- Most extragenital infections have no symptoms, and many occur without a simultaneous urethral infection, making urine-only testing insufficient for MSM.
- Retest patients for chlamydia or gonorrhea three months after treatment, regardless of potential partner treatment.



# GONORRHEA TREATMENT: ANTIBIOTIC RESISTANCE

- Recommended treatment:
  - 250 mg Ceftriaxone IM x 1 **WITH** 1 gram Azithromycin po x 1
- Encourage any patient treated for pharyngeal gonorrhea using an alternative regimen to return 14 days after treatment for a test of cure.
- Review clinical recommendations for suspected antibiotic treatment failure.
  - Antibiotic resistance to gonorrhea has been reported in Asia and Europe, and is expected to occur in the United States.
- Consider contacting your local health department or the National Network of STD Clinical Prevention Training Centers for consultation.
- Offer **expedited partner therapy** (EPT) to patients being treated for gonorrhea or chlamydia by dispensing oral medication or prescriptions for the treatment of their sexual partners.
  - Check state laws to ensure that EPT is allowable in your state.

# CLINICAL ASSESSMENT AND TESTING: SYPHILIS SCREENING

- Screen patients for syphilis at least annually.
- For patients with multiple partners, recommend more frequent screening (every three to six months).
- Consider using a treponemal Rapid Syphilis Test for persons without history of syphilis infection.
- Collaborate with health department staff to aid in the timely interview and partner services for patients with early syphilis infection.

# CLINICAL ASSESSMENT AND TESTING: HUMAN PAPILLOMAVIRUS (HPV) ASSESSMENT AND VACCINATION

- Discuss and offer HPV vaccine to all MSM patients, regardless of age and current HPV status, but remain cognizant of financial barriers to immunization and inform patients of potential out-of-pocket costs.
- Conduct an annual visual rectal exam and/or digital rectal exam for all MSM patients.
- MSM who do not report receptive anal intercourse may still acquire anal HPV.
- Consider anal pap smear if there is infrastructure locally to follow up abnormal results.
  - Many experts and some guidelines recommend anal pap smears for MSM living with HIV.
- Consider condyloma (genital warts) a marker of potentially oncogenic types of HPV.
  - Condyloma should be removed and trigger patient referral for high resolution anoscopy.
  - HPV types 16, 18, 31, 33, 45, 52 and 58 can cause cancer.
  - HPV types 6 or 11 can cause warts.
- Inform patients that HPV infection may clear, and is not necessarily a chronic infection like HIV.

# CLINICAL ASSESSMENT AND TESTING: VIRAL HEPATITIS VACCINATION AND SCREENING

- **Vaccinate for Hepatitis A if patients have not been previously vaccinated.**
  - Some experts recommend pre-vaccination screening on the same visit as vaccination.
- **Screen for chronic Hepatitis B and offer vaccine if patients have not yet been vaccinated or completed the full three doses.**
  - Screening should occur on the same date as vaccination.
- **Recognize that adult men over 30 years old are less likely to have been vaccinated for Hepatitis B as infants.**
- **Screen annually for Hepatitis C.**

# CLINICAL ASSESSMENT AND TESTING: MENINGITIS AND HERPES

- **Meningitis Risk and Vaccination:**

- Discuss sexual networks and history of Meningitis vaccination.
- Offer vaccine if traveling to areas with reported outbreaks.

- **Herpes Simplex Virus (HSV) Screening:**

- Routine blood screening for HSV1 and HSV2 antibodies is **NOT** recommended.
- Serum testing and cultures of skin lesions should be guided by the patient's clinical presentation and/or history of known exposure to a partner with HSV infection.

# CLINICAL ASSESSMENT AND TESTING: HIV SCREENING

- Use sex-affirming messaging, such as gain- and loss-framed messaging, when discussing prevention options.
- Screen patients for HIV at least annually.
- For patients with multiple partners, recommend more frequent screening (every three to six months).
- Use **fourth-generation HIV tests** for screening and prior to initiating (PrEP).
- If fourth-generation tests are not available, use lab or point-of-care antibody tests with whole or fingerstick blood specimens.
- Supplement antibody tests with HIV viral load testing (NAATs) if there is concern about acute HIV infection.

# CLINICAL ASSESSMENT AND TESTING: PEP

- Consider Post-Exposure Prophylaxis (PEP) for persons who report consensual or non-consensual exposure to HIV **within the past 72 hours**.
- Emphasize the need for rapid initiation of PEP and completion of the full 28-day regimen for maximal effectiveness.
- Patients with ongoing HIV risk should also be educated about **Pre-Exposure Prophylaxis (PrEP)** at the time of PEP initiation.

# CLINICAL ASSESSMENT AND TESTING: Pre-Exposure Prophylaxis (PrEP)

- Providers do not have to be HIV specialists to prescribe PrEP.
- Consider PrEP for persons who are eligible per the *CDC PrEP Clinical Guidelines*.
- Patients on PrEP should be screened for all STDs including HIV every three months.
- Because most STDs are asymptomatic, STD symptom assessment without screening is not sufficient for management.
- Discuss PrEP with patients living with HIV as a way to inform them of strategies their seronegative partners may use to prevent HIV infection.
- Encourage **condom** use among PrEP users to prevent other bacterial and viral STDs.



# WHAT STATE AND LOCAL STD PROGRAMS CAN DO...

- Incorporate this document and listed resources to educate providers about quality standards for the health care of gay, bisexual, and other MSM.
- Link to the standards and listed resources on STD program websites.
- Encourage health plans or provider groups to adopt quality improvement activities based on the standards.
- Effective strategies for improving rates of testing include standing orders for tests, and self-collected rectal and pharyngeal specimens when a full exam is not feasible.
- Partner with national and community-based organizations to promote and educate consumers about optimal sexual health care for gay, bisexual, and other MSM.
- Identify and link providers to laboratories that have validated rectal and pharyngeal specimens for gonorrhea and chlamydia testing.
  - The Association of Public Health Laboratories (APHL) can support this process.

# WHAT MEDICAL PROVIDERS AND PLANS CAN DO...

- **Ensure that clinical settings are LGBT-friendly and affirming, including providing cultural competency training and monitoring performance of all clinic staff.**
- **Ensure providers receive cultural competency training specific to sexual history taking and MSM sexual health care.**
- **Document sexual orientation and gender identity in health records to inform health care decision-making and enable quality measurement of health care.**
- **Incorporate quality standards and adopt quality improvement activities related to MSM sexual health care.**
- **Consider standing orders for patients with multiple partners to reduce barriers to testing.**
- **Consider self-collected specimens to reduce barriers to testing if there are concerns about the time required to conduct a full exam.**

# WHAT ACADEMIC INSTITUTIONS CAN DO...

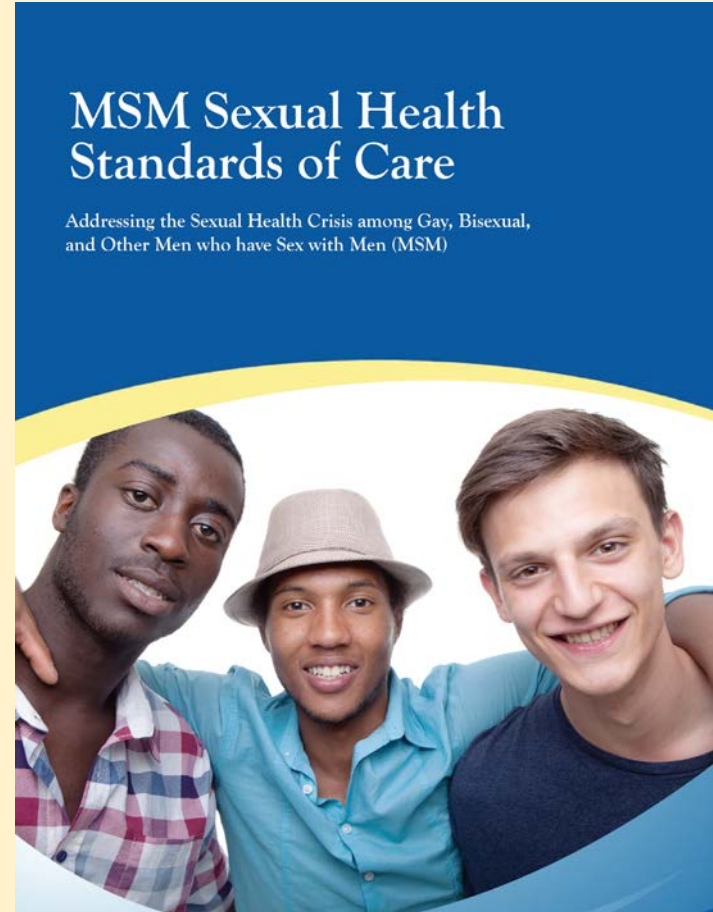
- **Incorporate these standards into medical training for medical health professionals, including nurses, nurse practitioners, physicians, and physician assistants.**
- **Build learners' knowledge, skills, and abilities in conducting quality, LGBT-affirming sexual history taking as a core activity.**
- **Educate, model, and incorporate practice of all aspects of the physical exam in a sensitive way.**
- **Educate medical professionals on how to craft gain-frame, sex-positive messaging for all patients, including gay, bisexual, and other MSM.**
- **Provide opportunities for continuing education accreditation for experienced providers.**

# WHAT GAY, BISEXUAL, AND OTHER MSM CAN DO...

- **Become empowered to request the health care they need and deserve.**
- **Seek providers to whom they feel comfortable disclosing their sexual behaviors.**
  - Some large provider groups have lists of LGBT-friendly providers.
  - The Gay and Lesbian Medical Association has a searchable list of LGBT-friendly providers.
  - [www.haydenslist.com](http://www.haydenslist.com)
- **Ask for the tests that they think they need - not all providers will know to test for rectal and pharyngeal infections.**
  - NCSO and NASTAD have an optimal care checklist that can be used as a reference.

# CONCLUSIONS

Quality sexual health care is a right that should be afforded to all people. Working together as a community of providers, health departments, advocates, and consumers, we can shift the paradigm of sexual health to be inclusive of pleasure, and to meet the clinical needs of gay, bisexual, and other MSM of all races, ethnicities, and ages.



**CASE STUDY...**

# QUESTION #1

- **A 17-year-old asymptomatic male goes to the publicly funded STD clinic to get screened. He has never been tested for STDs, including HIV, before. He admits to receptive oral intercourse in the preceding year – as well as multiple and anonymous partners. What should he be tested for?**
  - **HIV**
  - **Syphilis**
  - **Chlamydia/gonorrhea of the urethra**
  - **Chlamydia/gonorrhea of the throat**
  - **All of the above**

# ANSWER #1

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## QUESTION #2

- His labs results are as follows: Hepatitis B surface antibody and antigen – negative, HIV – non-reactive, RPR – non-reactive, NAAT of the urethra – negative for both chlamydia and gonorrhea, and NAAT of the throat – negative for chlamydia but positive for gonorrhea. What is the appropriate management of this patient?
  - Collect a specimen of the throat for gonorrhea culture and antibiotic sensitivity testing
  - Treat with Azithromycin 1 gram by mouth as a one-time dose
  - Treat with Cefixime 400 mg AND Azithromycin 1 gram - both by mouth and as one-time doses
  - Treat with Ceftriaxone 250 mg IM as a one-time dose
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## QUESTION #3

- **How else should this patient be appropriately managed?**
  - His sex partners should be elicited, tested, and treated
  - He should be immunized against hepatitis A and B
  - He should be offered PrEP
  - He should be rescreened for STDs 3-6 months after treatment
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## ANSWER #3

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