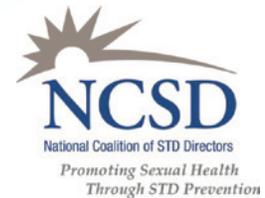


# MSM Sexual Health Standards of Care

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





The National Coalition of STD Directors (NCS D) is a partnership of public health professionals dedicated to advancing effective STD prevention programs and services in every community across the country. NCS D does this as the voice of their membership. NCS D provides leadership, build capacity, convene partners, and advocate. For more information, visit [www.NCSDDC.org](http://www.NCSDDC.org).

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. NASTAD does this work by strengthening domestic and global governmental public health through advocacy, capacity building, and social justice. For more information, visit [www.NASTAD.org](http://www.NASTAD.org).

The National Network of STD Clinical Prevention Training Centers (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. The NNPTC provides health professionals with a spectrum of state-of-the-art educational opportunities including experiential learning with an emphasis on STD treatment and prevention.



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\* NOTE: Listed organizations reflect the Blue Ribbon members' affiliations during the March 2015 meeting.

## Foreward

We are faced with a sexual health crisis for gay, bisexual, and other men who have sex with men (MSM). In 2015, 82 percent of male primary and secondary syphilis cases and 70 percent of new HIV cases<sup>2</sup> were among MSM. Disparities in race/ethnicity and age are also staggering, with young Black and Latino MSM bearing the greatest burden of STD and HIV infections. Medical providers and health departments have long needed a standard of care for the sexual health of gay, bisexual, and other MSM. We must reinvigorate the health care field with the tools to better engage MSM in the care continuum, as individual health care providers and as a larger community, or health disparities will continue to flourish.

Health care providers remain vital to our progress, and we congratulate the exemplary providers and encourage them to share their strategies with those not as well-versed in MSM sexual health. We strive to 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.

This MSM Sexual Health Standards of Care is a natural progression from materials developed by the National Coalition of STD Directors (NCSD) and the National Alliance of State and Territorial AIDS Directors (NASTAD): [\*Providing Optimal Care for Your MSM Patients. For Men Only: Your Sexual Health\*](#), and the toolkit [\*Addressing Stigma: A Blueprint for Improving HIV/STD Prevention and Care Outcomes for Black and Latino Gay Men\*](#). This document builds on the foundation laid by those materials and the triumphant efforts of so many dedicated advocates.

The recommendations in this document come from a wealth of clinical and programmatic experience including pleasure in the sexual health discourse. They also tackle the disease burden disproportionately faced by MSM. While we primarily educate providers, we must also 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.

We thank the many members of our Blue Ribbon Panel who tirelessly dedicated themselves to bringing this document to fruition. We remain committed to equipping providers with the best tools possible. NCSD and NASTAD also utilize the Gay Men's Health Equity Workgroup for additional expertise in MSM sexual health.

# 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). 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.

Implementation of quality sexual health care must be set in the context of social determinants of health. Clinical

environments and systems should be thoughtfully designed to be inclusive of lesbian, gay, bisexual, and transgender (LGBT) patients and patients of all races and ethnicities. Clinic staff, from receptionists to clinicians, should be trained and assessed for LGBT inclusivity in their interactions with patients.

Screening should occur at least annually, and every three to six months for sexually active MSM with multiple partners. The recommendations of the Blue Ribbon Panel suggest that providers offer the following to all of their gay, bisexual, and other MSM patients. Please note that this document is focused on cisgender men who have sex with cisgender men. Some of the material may also apply to transgender women, depending on their sexual practices they engage in. Whitman-Walker Health has an excellent document to guide sexual health conversations with transgender patients (see Appendix A).

## Sexual Health Protocol At-A-Glance

Culturally Competent Staff & LGBT-friendly Environment		Comprehensive sexual history	Mental health assessment and referrals	Counseling about condoms, lubrication, enemas, and douches	Discussion about sexual satisfaction and pleasure
		Visual exam to check for signs of HPV, syphilis, or other STDs			
		Urethral swab or urine-based chlamydia and gonorrhea screening	Rectal and pharyngeal chlamydia and gonorrhea screening		
		Syphilis screening	HIV screening	Hepatitis C screening	
		Hepatitis A vaccine	Hepatitis B vaccine	HPV vaccine	
		Post-exposure prophylaxis, as indicated	Pre-exposure prophylaxis, as indicated	Expedited Partner Therapy for chlamydia or gonorrhea infection	

## Goals and Objectives of the Blue Ribbon Panel

NCSD, in partnership with NASTAD and the NNPTC, hosted a meeting on March 19-20, 2015, titled *Improving the Sexual Health of MSM through Establishing a Sexual Health Standard of Care*. This convening, supported by MAC AIDS Fund, included participants from academia, city and state health departments, the CDC, NCSD, and NASTAD to form a Blue Ribbon Panel of sexual health experts. The core goal of the meeting was to develop optimal standards of client-focused clinical care and communication for gay, bisexual, and other MSM. The three objectives of the meeting were to:

- Convene a strategic consultation of experts to work toward developing a consensus of MSM sexual health needs
- Foster shared understanding among interested partners in STD/HIV prevention about a 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 and Stigma

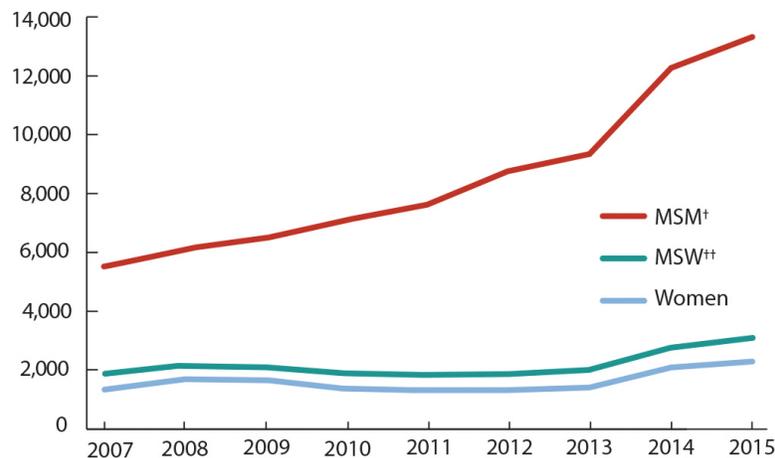
Before delving into clinical approaches to sexual health, it is vital to set the social landscape in which MSM are operating

before they walk through a clinic door. There is 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.

For example, the unemployment rate for Black men is 10.4 percent, and for Latino men 6.6 percent.<sup>3</sup> Unemployment reduces access to quality health insurance for those individuals and their families. Additionally, the mass incarceration of Black and Latino men, who comprise 58 percent of all prisoners despite making up only 25 percent of the population,<sup>4,5</sup> 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. Throughout the last decade, there have been outbreaks of syphilis, gonorrhea, and HIV in Black and Latino MSM. In 2015, MSM accounted for more of these cases than heterosexual men or women in all racial and ethnic groups, comprising 82 percent of all male primary and secondary syphilis cases<sup>6</sup> (Figure 1). Rates of new HIV infection by race and age among MSM point to the urgent need for interventions that address race and age disparities among MSM populations, in particular among young Black and Latino MSM<sup>7</sup> (Figure 2).

Gay and Bisexual Men Face Highest – and Rising – Number of Syphilis Infections



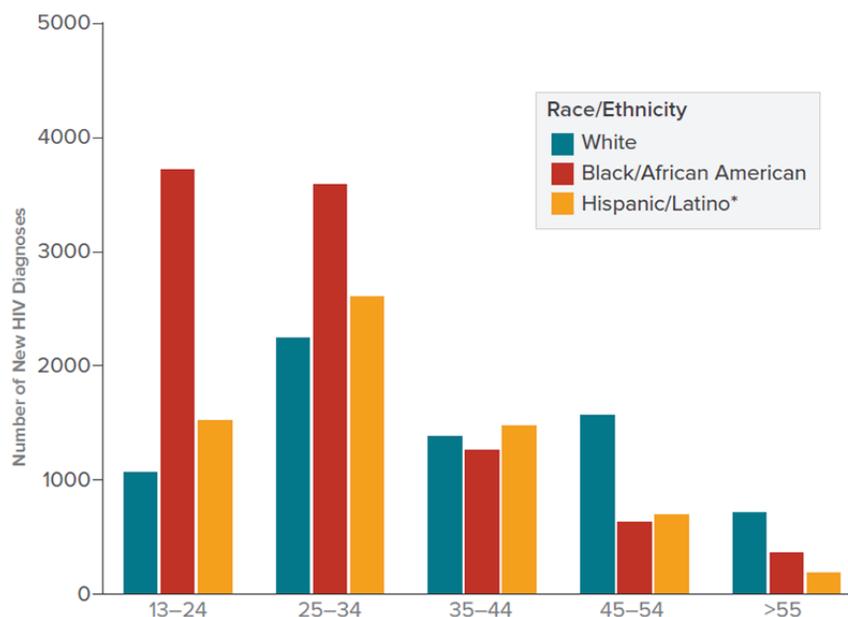
<sup>†</sup>Men who have sex with men

<sup>††</sup>Men who have sex with women

Note: Based on available data from states reporting sex of sex partners

Source: CDC

Figure 2. Estimated HIV Diagnoses Among Men Who Have Sex With Men, by Race/Ethnicity and Age at Diagnosis, 2014—United States



\* Hispanics/Latinos can be of any race

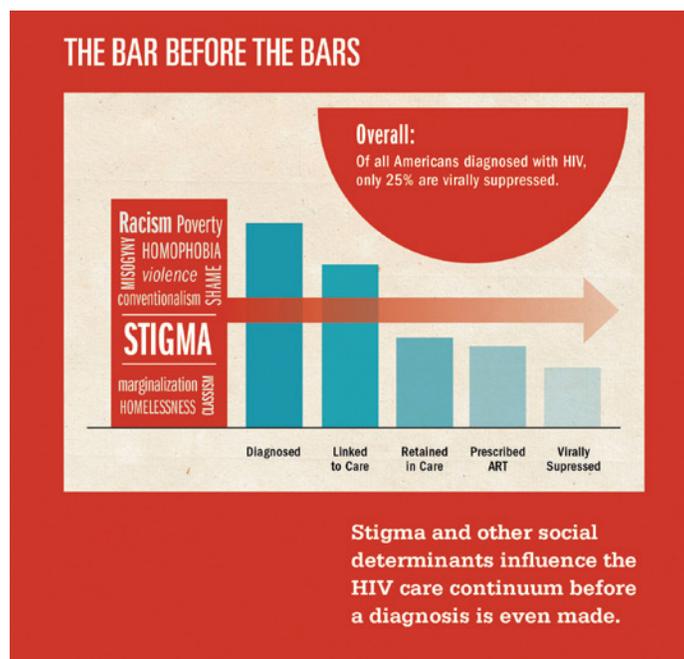
Source: CDC. Diagnoses of HIV infection in the United States and dependent areas, 2014.

*HIV Surveillance Report 2015;26.*

Stigma, an indicator that negatively marks a person or group for a specific characteristic or behavior, is another barrier to optimal care for MSM. Stigma 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<sup>8</sup> and many expect health care providers to initiate sexual health discussions.<sup>9</sup> For example, only 25 percent of patients receiving care in Ryan White clinics report that they discuss HIV transmission prevention with their providers,<sup>10</sup> and only six percent of patients diagnosed with HIV report discussing sexual practices with their primary providers.<sup>11</sup>

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.<sup>12</sup> 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.

To that end, NCSd and NASTAD created a document, [Addressing Stigma: A Blueprint for Improving HIV/STD Prevention and Care Outcomes for Black and Latino Gay Men](#) and other MSM.<sup>13</sup> 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 (See Figure 3).



This image is taken from the NASTAD/NCSD toolkit, [Addressing Stigma: A Blueprint for Improving HIV/STD Prevention and Care Outcomes for Black and Latino Gay Men](#). It illustrates how stigma prevents Black and Latino MSM from achieving viral suppression.

Interventions to reduce STD and HIV infection should focus on the populations most affected, accounting for social determinants and the experience of stigma, and use a community-based approach to ensure cultural competency and acceptance.

## Primary Findings from the Blue Ribbon Panel

The MSM Sexual Health Standards of Care described below combine current CDC recommendations for quality sexual health care for MSM with recommendations from the collective expertise of the Blue Ribbon Panel. See Appendix A for additional resources.

## 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.<sup>14</sup> 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

The following information should be included in discussions with gay, bisexual, and other MSM patients.

### 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.<sup>15</sup>
- 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.<sup>16,17</sup>

- 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.
- Have free condoms available in the office, waiting area, and restrooms. Condom distribution programs are effective for reducing STDs, including HIV.<sup>18</sup>
- 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.

### **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**

According to CDC, one in three primary care providers and nurses have not heard about pre-exposure prophylaxis (PrEP),<sup>19</sup> and the lack of extragenital screening for gonorrhea and chlamydia are missed opportunities for diagnosis and subsequent treatment. Incorporating the following clinical recommendations will ensure that MSM patients receive comprehensive sexual health care.

### **Chlamydia and Gonorrhea Screening**

- Test for chlamydia and gonorrhea at least annually, and every three-six months for men who have factors that may increase their potential exposure to STDs.<sup>20</sup> Nucleic Acid Amplification Tests (NAATs) should be used wherever available for chlamydia and gonorrhea testing.<sup>21</sup>
- 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).<sup>22</sup>

- Screen for urethral gonorrhea and chlamydia through urine-based testing, or with a clinician-collected or self-collected urethral swab.<sup>23</sup>
- 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.<sup>24</sup> Extragenital tests for gonorrhea and chlamydia are not approved by the Food and Drug Administration, but many commercial and public health laboratories have verified the test for use.
- Encourage any patient treated for pharyngeal gonorrhea using an alternative regimen to return 14 days after treatment for a test of cure.<sup>25</sup>
- Review clinical recommendations for suspected antibiotic treatment failure.<sup>26</sup> 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. NCSD maintains updated information about state EPT laws.<sup>27</sup>
- Retest patients for chlamydia or gonorrhea three months after treatment, regardless of potential partner treatment.<sup>28</sup>

### **Syphilis Screening**

- Screen patients for syphilis at least annually. For patients with multiple partners, recommend more frequent screening (every three to six months).<sup>29</sup>
- Consider using a treponemal Rapid Syphilis Test for persons without history of syphilis infection.<sup>30</sup>
- Collaborate with health department staff to aid in the timely interview and partner services for patients with early syphilis infection.<sup>31</sup>

### **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.<sup>32</sup>

- 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.<sup>33</sup>
- 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 and HPV types 6 or 11 can cause warts.<sup>33</sup>
- Inform patients that HPV infection may clear, and is not necessarily a chronic infection like HIV.

### **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.<sup>34</sup>
- 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.<sup>35</sup>
- Recognize that adult men over 30 years old are less likely to have been vaccinated for Hepatitis B as infants.<sup>36</sup>
- Screen annually for Hepatitis C.<sup>37</sup>

### **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.<sup>14,15</sup>

### **HIV Screening, PEP, and PrEP**

- Use sex-affirming messaging, such as gain- and loss-framed messaging, when discussing prevention options.<sup>38</sup>
- Screen patients for HIV at least annually. For patients with multiple partners, recommend more frequent screening (every three to six months).<sup>39</sup> 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.<sup>40</sup>
- 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.<sup>41</sup> Patients with ongoing HIV risk should also be educated about PrEP at the time of PEP initiation.
- Providers do not have to be HIV specialists to prescribe PrEP. Consider PrEP for persons who are eligible per the CDC *PrEP Clinical Guidelines*.<sup>42</sup> Patients on PrEP should be screened for all STDs including HIV every three months.<sup>42</sup> 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.

Appendix B provides case studies to illustrate best practices in applying these recommendations in a clinical setting.



## How to Implement the MSM Standards of Sexual Health Care

**State and Local STD Programs** can implement these standards by doing the following:

- 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.

**Medical Providers and Plans** can incorporate these standards into medical practice by doing the following:

- 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. Training resources are listed in Appendix A.
- 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.

**Academic institutions** can incorporate these standards into medical training for medical health professionals, including nurses, nurse practitioners, physicians, and physician assistants, by doing the following:

- 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

**Gay, bisexual, and other MSM consumers** can be empowered to request the health care they need and deserve by being encouraged to do the following:

- 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.
- Ask for the tests that they think they need—not all providers will know to test for rectal and pharyngeal infections. NCSF 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.



## APPENDIX A: Resources

### Stigma, Inclusivity, and Sexual History Taking

*Addressing Stigma: A Blueprint for Improving HIV/STD Prevention and Care Outcomes for Black and Latino Gay Men* (NCSD and NASTAD). This report provides recommendations to help health centers reduce stigma around sexuality, race, and gender identity in order to enhance HIV/STD prevention services for Black and Latino MSM. [http://www.ncsddc.org/sites/default/files/nastad\\_ncsd\\_report\\_addressing\\_stigma\\_may\\_2014.pdf](http://www.ncsddc.org/sites/default/files/nastad_ncsd_report_addressing_stigma_may_2014.pdf)

*Provider Perspectives on the Needs of Gay and Bisexual Male and Transgender Youth of Color* (The Williams Institute). This guide includes recommendations for improving support for LGBTQ youth of color in clinical settings. <http://williamsinstitute.law.ucla.edu/wp-content/uploads/ACCESS-final-rev-aug-2013.pdf>

*Sexual History Taking Resources* (National Network of Prevention Training Centers). This bank of resources provides tools and training for improving skills related to sexual history taking. <http://nnptc.org/resourcetags/sexual-history/>

*Clinician Guide to Sexual History Taking* (California Department of Public Health). This document provides specific questions that follow the 5-P's approach to sexual history taking. <https://www.cdph.ca.gov/pubsforms/Guidelines/Documents/CA-STD-Clinician-Guide-Sexual-History-Taking.pdf>

*Healthcare Equality Index 2016* (Human Rights Campaign). This report rates 2,060 healthcare facilities throughout the U.S. on their inclusion and LGBT equality. <http://www.hrc.org/campaigns/healthcare-equality-index>

*Resources for Providers and Researchers* (Gay and Lesbian Medical Association). This site includes resources for improving cultural competence for LGBT patients and a provider directory. <http://www.glma.org/index.cfm?fuseaction=Page.viewPage&pageId=940&parentID=534>

*Safer Sex for Trans Bodies* (Whitman-Walker Health). This resource relates to transgender sexual health and can serve as a complement to this document with greater body inclusivity. <https://www.whitman-walker.org/wp-content/uploads/2014/11/Trans-Safer-Sex-Guide-FINAL-1.pdf>

*Understanding and Eliminating Health Disparities* (National LGBT Health Education Center). This report outlines basic LGBT terminology, demographics, and health disparities, and describes key issues to address within the healthcare setting in order to provide LGBT-friendly medical care. [http://www.lgbthealtheducation.org/wp-content/uploads/12-054\\_LGBTHealtharticle\\_v3\\_07-09-12.pdf](http://www.lgbthealtheducation.org/wp-content/uploads/12-054_LGBTHealtharticle_v3_07-09-12.pdf)

*Legislative trends for STD Prevention in 2014, Part II: EPT* (NCSD). This article outlines the changes in EPT laws from 2006 to 2014, with information about the status of EPT laws in each state. <http://www.ncsddc.org/blog/legislative-trends-std-prevention-2014-part-ii-ept>

### National Clinical Guidelines and Recommendations

*2015 STD Treatment Guidelines* (CDC). These guidelines provide clinical guidelines for prevention, screening, treatment, and partner management. <http://www.cdc.gov/std/tg2015/>

*HIV Guidelines and Recommendations* (CDC). This site includes links to clinical guidelines for HIV prevention, testing, and treatment. <http://www.cdc.gov/hiv/guidelines/>

*HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C* (American Association for the Study of Liver Disease). <http://www.hcvguidelines.org/>

### Clinical Resources and Training

*Providing Optimal Care for Your MSM Patients* (NCSD and NASTAD). This brochure is intended as a guide for providers and can be used as a supplement to these standards. [http://www.ncsddc.org/sites/default/files/provider\\_brochure2.pdf](http://www.ncsddc.org/sites/default/files/provider_brochure2.pdf)

*The National Network of STD Clinical Prevention Training Centers*. These training centers offer resources, training, and clinical consultation for STD providers across the United States. <http://nnptc.org/>

*His Health* (NASTAD). This resource supports building capacity to deliver high-quality, affirming care for Black LGBT patients with an accredited CME/CNE course series. <https://www.hishealth.org/>

*A Clinician's Resource for STDs in Gay Men and Other MSM* (California Department of Public Health). This comprehensive guide includes information about clinical manifestations, screening protocols, treatment recommendations, and model language for intake forms for MSM patients. <http://www.cdph.ca.gov/programs/std/Documents/MSMToolkit.pdf>

*A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (SAMHSA). This guide provides background information on cultural and clinical considerations for counselors, therapists, administrators, and other substance abuse treatment providers working with LGBT clients. <https://store.samhsa.gov/shin/content/SMA12-4104/SMA12-4104.pdf>

*Preventive Male Sexual and Reproductive Health Care: Recommendations for Clinical Practice* (Male Training Center for Family Planning and Reproductive Health). These recommendations include discussion of reproductive health options for men who are interested in family planning. [http://www.maletrainingcenter.org/wp-content/uploads/2014/09/MTC\\_White\\_Paper\\_2014\\_V2.pdf](http://www.maletrainingcenter.org/wp-content/uploads/2014/09/MTC_White_Paper_2014_V2.pdf)

## **Resources for Advocates and Consumers**

*For Men Only: Your Sexual Health* (NCSD and NASTAD). This brochure is intended as a guide for gay, bisexual, and

other MSM of color. [http://www.ncsddc.org/sites/default/files/patient\\_brochure2.pdf](http://www.ncsddc.org/sites/default/files/patient_brochure2.pdf)

*Well Versed* (NASTAD). A consumer-facing tool for Black Gay, Bisexual, and MSM in having conversations with their health care provider. <https://www.wellversed.org/>

*CDC Fact Sheet: What Gay, Bisexual and Other Men Who Have Sex with Men Need to Know About Sexually Transmitted Diseases* (CDC). This fact sheet is intended for MSM consumers. <http://www.cdc.gov/std/life-stages-populations/stdfact-msm.htm>

*Building Healthy Online Communities* (NCSD). A partnership of public health and mobile dating app owners in to support gay men's sexual health. <https://www.bhocpartners.org>  
*PrEPLocator.org* (Emory University). This website lists pre-exposure prophylaxis (PrEP) prescribers in the United States using zip codes. There are additional settings for uninsured persons and persons in need of patience assistance. <https://prelocator.org/>

*Straight for Equality in Healthcare Chapter Field Guide* (PFLAG). This resource describes actions that advocates and consumers can do to improve healthcare for LGBT patients. <https://www.pflag.org/publication/straightforequalityhealthcarechapterguide>

*Gay and Lesbian Medical Association Provider Directory*. This directory is a searchable list of primary care and other providers that have affirmed their commitment to LGBT-inclusive health care. <http://www.glma.org/index.cfm?fuseaction=Page>.

## APPENDIX B: Case Studies

Below are two examples and follow-up questions were provided by physicians on the Blue Ribbon Panel. These case studies illustrate some of the considerations when discussing an approach to sexual health care that is affirming and strengths-based.

### Case Study #1

*A 23-year-old white male presents to your practice to be treated for syphilis. The patient states that he is “straight,” but that he sometimes has sex with other straight men. He does not use condoms for anal sex because he states that his older partners prefer “raw” sex. The patient denies being a receptive anal sex partner. When asked permission to do an exam of his rectum, he declines exam. A review of his medical record demonstrates a previous diagnosis of rectal chlamydia. The doctor approaches him about PrEP, but the patient states that he does not think he needs it. He says that it is good for “gay guys,” but not for him. He has heard that all guys who use PrEP are bottoms and that taking PrEP means that they are “whores.”*

#### **How do you deal with stigma related to same-sex behaviors in this patient?**

It is important to meet the patient where he is. Not every MSM fits neatly into a category of gay, bisexual, etc. Being

open-minded and open in language to match how the patient expresses his sexuality is critical. Misnaming him, or forcing him into a category based on provider experience, is both detrimental to the relationship and potentially stigmatizing. It is important to allow the patient to have the self-efficacy to make decisions while still providing him with care that matches his sexual life.

#### **What is the strategy for providing him good clinical care given the limits he has set?**

Do what you can and what he allows you to do. If he will not let you examine his genitals, then offer STD testing alone. If he will not let you swab his anus, offer him the option of self-collection of swabs. After all, it is his body, and he calls the shots. Meeting him where he is at will allow for frank discussions and alliance building that a more dictatorial strategy would potentially compromise.

## Case Study #2

*Paul is a 19-year-old black man who is living with HIV who presents with dysuria (painful urination). He is a member of the house ball community and refers to them as his family. His biological family kicked him out of their house when they discovered his HIV medications under his mattress. Paul has not engaged with any medical care for nearly two years. Paul's last T cells were 378 and his VL was undetectable. He hasn't taken meds for over 18 months. He currently does not have housing. He uses hook-up apps to find people whose apartments he can sleep in, often in exchange for sex. When you examine Paul, you find that he has some rectal bleeding. He confirms that he was recently sexually assaulted by someone he met on an app.*

### **How does the issue of equity for LGBTQ youth enter the story of movements for race equity?**

It is important for providers taking care of LGBTQ youth. It is equally important to address the intersectionality that exists between age, race/ethnicity, and sexual orientation that often is neglected by LGBTQ health initiatives.

While there are overlapping disparities among racial/ethnic and sexual and gender minorities, there are unique differences that impact Black and Latino LGBTQ youth that need to be considered when caring for these populations. Paul's experiences as a Black man in our society need to be taken into account and considered when providing health services.

This understanding needs to be reflected in the way that we communicate with Paul and how we formulate our health plans or strategies with, and for, him. For example, as providers we should consider that many African Americans may have a general distrust of the healthcare system. This and other issues may impact Paul's adherence to medications. It is important for clinicians to see Paul as he exists outside of his marginalization. Though he might be at a sensitive social location--his culture, resilience, and individuality should still

be centered. Often times, well-meaning individuals get into the habit of equating certain identities as lived oppression and nothing more. Consider his marginalization and keep it in mind, but don't have that substitute over his agency and uniqueness as an individual. He is not just a black MSM and treating him holistically can affirm this.

### **How can HIV or sexual health concerns be made more important when basics in Paul's hierarchy of needs are not being addressed?**

It's very challenging for patients to focus on sexual (or HIV and STD) health concerns when some basic needs are not being addressed. We know that the most fundamental causes of health disparities are socioeconomic disparities. Providers will find this information helpful in establishing a relationship with their patients and in developing a more effective therapeutic plan to inquire and identify potential socioeconomic stressors (lack of money, homelessness, etc.) that may compete with the patient's ability to participate in the management of his sexual health. This is true for almost any kind of patient-provider relationship, but it is particularly important when working with LGBTQ youth, especially youth from disadvantaged communities.

It is equally important for providers to be aware of support services and other resources available in their communities, and to have a referral system in place to assist those patients with identified needs. Paul's history merits an assessment of his social and possible mental health needs. He can benefit from emergency housing or some assistance that may provide temporary shelter until things are more stable and he can find more permanent housing, employment assistance, access to food services (food pantry or food stamps), and social and emotional support that may help him to recover from what seems to be a low point in his life. The expectation that Paul will be attending clinical appointments regularly or taking medications every day unless some of these major life issues are addressed is unrealistic.



## APPENDIX C: References

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