MSM: Clinician's Guide to Incorporating Sexual Risk Assessment in Routine Visits

Background

More than 260,000 men who have sex with men (MSM) have died of AIDS in the United States (3). Despite significant reductions in HIV incidence among this population in the 1980s, associated with decreases in high-risk sex (2), MSM are still disproportionately affected—with an estimated 42% of new HIV infections each year (1). A recent rise in sexually transmitted diseases and risk behaviors among MSM, documented in several cities (1,2), is concerning as it may herald a resurgence of HIV infections among MSM. With these trends there remains a great need for clinicians to address sexual health issues. A recent survey showed only 20% of patients had discussed risk factors for HIV with their provider in the last five years. Of those respondents only 21% reported that the provider had started the discussion (6). Another survey reported that only 11-37% of primary care physicians routinely takes a sexual history from new adult patients (5). One study documented physician awkwardness around issues of sexual health and HIV leading to incomplete discussions of these topics, despite interest from their patients (9). Routine health maintenance visits are opportunities for clinicians to practice primary prevention of HIV infection through sexual risk assessments.

What Is Known?

By the end of the 1980s public health researchers were noting difficulty in maintaining sexual risk reductions over long periods of time among MSM (2). Several studies confirmed this observation in the last decade, documenting increasing rates of unprotected anal intercourse in this population (2). The prevention messages are not working or are not reaching those most in need of them.

What Barriers Are at Work Here?

Clinicians must consider social and cultural variables, mental health and substance abuse, in addition to specific risk behaviors when tailoring prevention messages to MSM. Each can create barriers to turning prevention messages to changes in behavior for patients.

Stigma. Gay-identified MSM frequently face stigma in every aspect of their lives. African-American and Latino MSM face racial discrimination from society at large and homophobia from their own ethnic groups. They often feel unaccepted in the mainstream gay community. Both African-American and Latino MSM are more likely to identify as heterosexual than their white counterparts (1). A fear of alienation and lack of community support may prevent MSM in both groups from identifying as gay and, thus, limit exposure to prevention messages (4). Unpublished data from Malebranche *et al* particularly highlights how the health care setting becomes a microcosm of larger society where African-American MSM face prejudice and discrimination on a daily basis (8). Perception of stigma from a clinician can irrevocably harm the therapeutic relationship and prevent honest disclosure and appropriate prevention messages.

Socioeconomic status. Lower socioeconomic status often results in poorer health outcomes. However, African-American MSM are disproportionately affected by homelessness, substance abuse, and sexually transmitted infections, all correlated with a lower socioeconomic status (1). Foreign-born Latino MSM, fearing report to immigration services, often do not seek health care services. Native American or Alaskan MSM are at both economic and geographical disadvantages when considering access to prevention messages (4).

Cultural norms. Although not applicable to every individual in a particular group, cultural norms can affect the way MSM disclose information and incorporate prevention messages in the health care setting. The importance of pleasant, conflict-free (*simpatía*) and close (*familismo*) relationships with family may prevent openness among some Latino MSM regarding sexuality in favor of avoiding potential shame, disgrace, or embarrassment (1). Homosexuality conflicts with *machismo*, or masculinity, which has a high value in many Latino cultures. A diverse range of cultures and languages prevents Asian/Pacific Islanders from receiving appropriate prevention messages (1). Discussions of sexual health, including homosexuality, are not part of their cultural norms (4).

False assumptions. Prevention messages issued during the past two decades reached the gay community during the last two decades, but for several reasons are becoming ineffective. In surveys MSM report difficulty in sustaining behavior change for a lifetime (1,3). Additionally, studies have shown that newer HIV treatments (i.e., protease inhibitors and combination therapies) lead some MSM to take sexual risks, being more optimistic about treatment options if they were to seroconvert (1,2,3). Similarly, the false assumption that HIV-positive men on antiretroviral therapy are unlikely to transmit the virus contributes to risk-taking and unprotected anal sex among some MSM (2,3). In summary, false beliefs in the established gay community create barriers to behavior change based on prevention messages.

Mental health and substance abuse. Although not causal, sexual risk taking and HIV infection itself correlates with substance abuse and depression, among other mental health disorders (e.g., loneliness, depression, anger, low self-esteem), in surveys of MSM (2).

What Can Be Done?

Asking about sexual behavior should be part of every routine visit, regardless of the patient's identified sexual orientation or marital status. Sexual behavior exists on a continuum. Eliciting specific risk behaviors can direct the clinician in assessing the patient's knowledge, selecting appropriate prevention messages, and determining the need for sexually transmitted infection or HIV testing. Knowing that there are significant barriers in place between clinician and patient in addressing sexual health, utilizing a sensitive approach is key to attaining pertinent information.

What Is the Best Approach?

The Mountain-Plains Regional AIDS Education Training Center developed a useful model for approaching sexual risk assessment (7) modified below.

1) Assess risk at every new patient visit and when there is evidence that behavior is changing.
2) Sexual risk assessment should be part of a comprehensive health risk assessment, including use of seatbelts and firearms, domestic violence, and substance abuse.
3) Qualify the discussion of sexual health emphasizing that it is a routine part of the interview and underscore the importance of understanding sexual behavior in providing quality care. Remind the patient that your discussion is confidential. You may need to negotiate what ultimately becomes part of the medical record.
    a. "In order to take the best possible care of you I need to understand in what ways you are sexually active."
    b. "Anything we discuss stays in this room."
4) Avoid use of labels like "straight," "gay," or "queer," or terms that do not relate to specific behaviors. As an example, a significant percentage of both African-American and Latino MSM identify as heterosexual, even though they may practice anal intercourse with other men (1).

5) Be careful while taking a history, in making assumptions about behavior based on age, marital status, disability or other characteristics.
6) Ask specific questions regarding behavior in a direct and non-judgmental way.
   a. "Are you sexually active?"
   b. "Do you have sex with men, women, or both?"
   c. Determine the number of partners, the frequency of condom use, and the type of sexual contact (e.g., oral, anal, genital).
7) Assess the patient's history of sexually transmitted infections (STIs).

8) If the patient's responses indicate a high level of risk (e.g., unprotected sexual activity, significant history of STIs), determine the context in which these behaviors occur, including concurrent substance use and mood state.
    a. "I want to get an understanding of when you use alcohol or drugs in relation to sex."
    b. "How often are you high or drunk when you're sexually active? How does what you do change in that case?"
    c. "How often do you feel down or depressed when you're sexually active? Do you act differently?"
9) Summarize the patient's responses at the end of the interview.

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