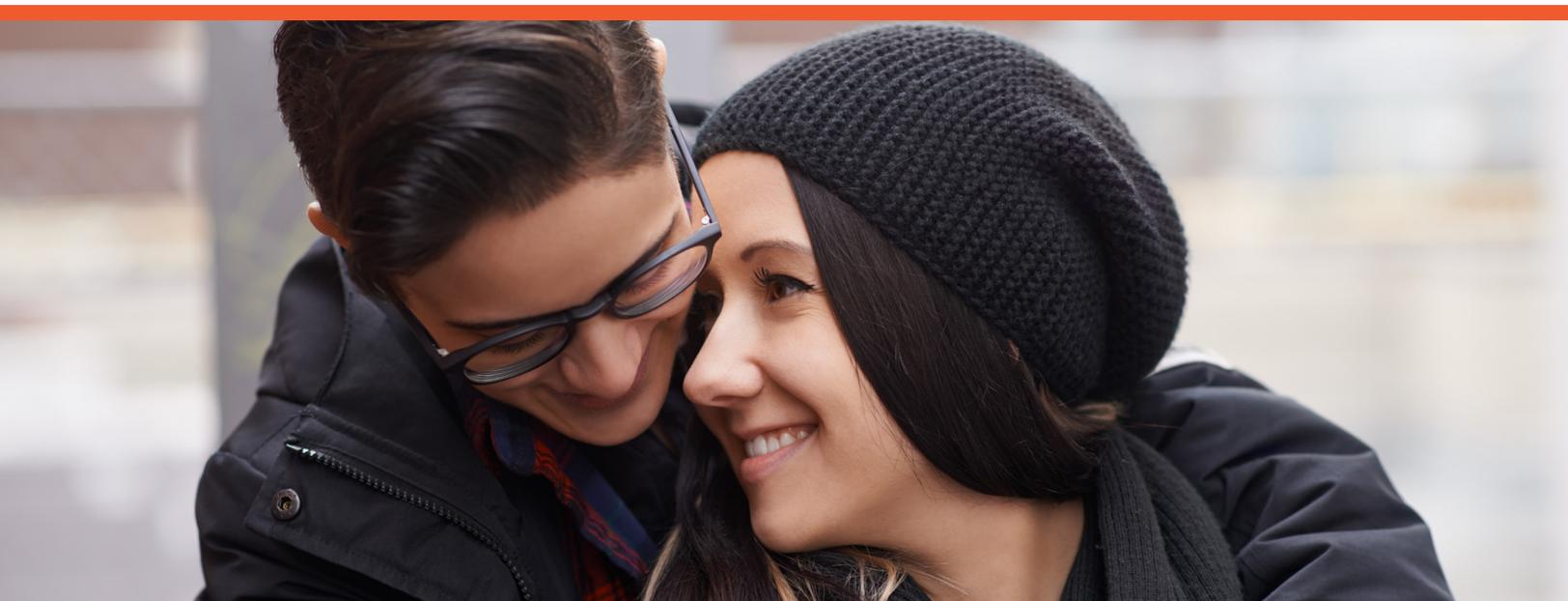




Addressing HIV and Sexually Transmitted Infections among LGBTQ People:

A Primer for Health Centers | 2019



NATIONAL LGBT HEALTH
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Introduction

Some lesbian, gay, bisexual, transgender, and queer (LGBTQ) people face an increased risk for HIV and sexually transmitted infections (STIs). This increased risk is best documented for gay, bisexual, and other men who have sex with men (MSM), for whom rates of HIV, syphilis, and gonorrhea exceed those of the general population.¹ Transfeminine people are also at increased risk for HIV, with 49-times greater odds of infection in comparison to all adults.² The epidemiology of these infections among lesbians and other women who have sex with women (WSW) and transmasculine and non-binary people is not known.

The increased risk of HIV and STIs in these populations stems from both social and biological factors. Stigma and discrimination can foster unhealthy coping mechanisms, such as sexual risk behavior, and can impair access to health care, thereby limiting opportunities for screening and prevention. In addition, the susceptibility of the rectal mucosa to infection increases the risk of acquiring HIV and STIs for those who engage in condomless anal intercourse.

Health center clinicians can help address HIV and STIs among LGBTQ people by screening appropriately based on a comprehensive sexual history, providing culturally appropriate safer sex counseling, and offering biomedical prevention strategies, such as vaccinations and pre-exposure prophylaxis for HIV (PrEP).

Terminology

Terms related to LGBTQ people vary across communities and evolve over time. Here we define a few terms that may be unfamiliar to some. To read definitions of other LGBTQ terms, see “Glossary of LGBT Terms for Health Care Teams” (www.lgbthealtheducation.org/publication/lgbt-glossary).

Transfeminine describes people assigned male sex at birth who identify with femininity to a greater extent than with masculinity.

Transmasculine describes people assigned female sex at birth who identify with masculinity to a greater extent than with femininity.

Non-binary describes people whose gender identity blends or falls outside the traditional binary of girl/woman/female or boy/male/man.



Taking a history of sexual health

The first step in addressing HIV and STIs is to take a routine comprehensive sexual history that is inclusive of all people, including those who are LGBTQ. The purpose of the sexual history is to identify opportunities for screening and prevention and to address any sexual health concerns patients may have.^{3,4} The key to an inclusive sexual history is to ask open and non-judgmental questions about sexual behavior, avoiding assumptions based on the patient's sexual orientation and gender identity. A person's identity as LGBTQ does not necessarily predict or correlate with their sexual behavior. Risk for HIV and STIs is conferred by behavior, not identity. Nonetheless, knowing the sexual orientation and gender identity prior to the sexual history helps clinicians communicate in a more culturally appropriate manner, and prevents assumptions that all patients are heterosexual and cisgender (not transgender).

The following components of a comprehensive sexual history are adapted and expanded from the CDC's recommendations.³ Prior to beginning the sexual history, providers can first normalize the questions by letting patients know that these questions are asked routinely of all patients, and that the questions are important for their medical care and well-being.

Partners

Providers should inquire about who the patient is having sex with. These questions should be asked in a way that does not assume monogamy, gender, or anatomy of partners. One way to ask is: "Are you sexually active?" If yes, "Who are you having sex with?" and "Have you had sex with anyone else in the past year?" In addition, providers should determine if the patient is aware of any HIV or STI risk factors in their partners, such as injection drug use or engagement in transactional sex.

Practices

Providers should ask about the types of sex patients have had. Since patients may not understand terms such as "receptive anal intercourse," it may be helpful to inquire specifically about certain sexual practices using common terms. For example, clinicians may ask "Has anyone's penis been in your anus?" Providers may wish to preface this discussion with a general statement, such as "I am now going to ask detailed questions about the types of sex you have had, since this impacts how we screen you for sexually transmitted infections." Providers may find it helpful to educate themselves about common sexual practices and risk behaviors among LGBTQ people (see Resources).

Protection from STIs

Providers should determine what, if any, types of protection patients employ against HIV and STIs. Protective strategies may include condoms, or in the case of HIV, PrEP and/or HIV treatment for those living with the infection. Use of protection may vary by the type of sex act and/or partner (i.e., patients may use condoms with some partners but not others). To help inform risk-reduction counseling, providers can ask questions like "How do you decide when to use condoms?"

Past history of STIs

Knowing that a patient has a history of STIs may help estimate their risk for HIV and STIs going forward, and may provide a basis for preventive strategies such as PrEP. For example, CDC guidelines list a recent bacterial STI in an MSM as an indication for PrEP.⁵ In addition, some STIs, such as syphilis, require long-term clinical follow-up.

Pregnancy plans

Providers should ask about reproductive intentions. If a patient reports not wanting children but describes sexual practices that have a risk of pregnancy, contraception can be addressed. Providers should not make assumptions about pregnancy plans based on LGBTQ status, but should simply ask instead. Be prepared to offer referrals for LGBTQ-welcoming adoption, insemination, and surrogacy agencies.

Sexual function and satisfaction

Inquiring about concerns with sexual function or satisfaction not only elicits medically significant information, such as a history of erectile dysfunction, but also reduces sexual stigma by conveying that sexual health is an integral part of overall well-being. Although standardized sexual health questions help normalize the process and ensure equality of care provision, the provider must also remain empathic and sensitive to the patient's body language and any concerns the patient may raise. Questions can therefore be asked and answered in a more open-ended manner, based on time available and the patient and provider's agreed-upon communication style.⁶

Clinicians may worry that patients will be uncomfortable answering sexual history questions, or may themselves experience discomfort when asking questions. However, patients often want to discuss sexual health concerns with their providers. With practice, providers can learn to seamlessly and comfortably incorporate a comprehensive sexual history into the care they provide.



Screening for HIV and STIs

Using information from a comprehensive sexual history, providers can then recommend appropriate screening tests for HIV and STIs. The only LGBTQ population for whom STI screening guidelines have been specifically developed is MSM.

Men who have sex with men (MSM)

CDC recommends that sexually active MSM be screened for HIV, syphilis, hepatitis B, gonorrhea, and chlamydia (Table).⁷ Screening should be performed annually in sexually active MSM and more often in those at highest risk, based on the sexual history. MSM who take PrEP and are at increased risk for STIs should be screened at least every 3 months.⁷

- **HIV:** The HIV antibody/antigen test is the preferred screening test for HIV, because of its sensitivity for early infection. Nevertheless, providers and patients should understand that the test is not sensitive for infection acquired within the past two to three weeks due to the “window period” between infection and test positivity.
- **Syphilis:** A serum treponemal antibody or rapid plasma reagin (RPR) is the preferred screening test for syphilis.
- **Gonorrhea and Chlamydia:** Nucleic acid amplification testing (NAAT) for gonorrhea and chlamydia can be performed on oral, urethral, vaginal, endocervical, and rectal swabs as well as urine. The sensitivity for urethral infection of a first-catch urine specimen is the same as that of urethral swab, so there is no advantage to performing the urethral swab. Oral and rectal specimens can be self-collected by patients without impacting accuracy. It is crucial to test the oral and rectal sites among MSM who report oral and receptive anal sex; these sites account for most chlamydia and gonorrhea infections among MSM and are usually asymptomatic, so the clinician cannot rely on a lack of symptoms to determine the need for testing.

MSM who are living with HIV should be tested for hepatitis C at least annually with a hepatitis C antibody assay,⁷ in addition to tests for syphilis, gonorrhea, and chlamydia. They should also be screened for anal cytologic abnormalities due to human papillomavirus (HPV).⁸

Women who have sex with women (WSW)

Providers should not assume that WSW are at low risk for HIV and STIs and should instead determine risk based on the sexual history. At the very least, WSW should receive the screening tests recommended for all women, including an HIV test, chlamydia and gonorrhea screening for women up to 24 years, and cervical cytology.⁴

Transgender and non-binary people

CDC recommends that transgender, non-binary, and other gender minorities be screened for HIV and STIs based on current anatomy and an individualized risk assessment.⁷

Table: Sexually Transmitted Infection Screening Guidelines for Men Who Have Sex with Men*

Condition	Preferred screening strategy
HIV	HIV antibody/antigen assay
Syphilis	Treponemal antibody or rapid plasma reagin (RPR)
Gonorrhea	Nucleic acid amplification testing (NAAT) of the urine, pharynx, and rectum, as indicated by the sexual history
Chlamydia	NAAT of the urine and rectum, as indicated by the sexual history
Hepatitis B	Hepatitis B surface antigen, followed by vaccination if negative and prior vaccination cannot be confirmed
Hepatitis C[†]	Hepatitis C antibody
HPV-associated malignancy[‡]	Anal cytology

*Unless otherwise indicated, testing should be performed annually, or more often in those with the highest risk.

[†]Screening only formally recommended for MSM living with HIV and for HIV-uninfected MSM starting PrEP

[‡]Screening only formally recommended for MSM living with HIV



Counseling about safer sex

Several studies have demonstrated increases in condom usage after brief counseling interventions by clinicians.⁹⁻¹² These studies, however, were primarily performed in HIV clinics prior to the advent of PrEP or the recognition that HIV treatment effectively prevents transmission. In addition, these studies primarily focused on MSM; therefore, it is not clear if the same interventions would be as effective now, or if the benefits would extend to WSW or gender minority populations. Nevertheless, counseling about strategies to reduce the acquisition of HIV and STIs remains a mainstay of preventive care.

Strategies can include reducing the number of sexual partners, increasing the correct and consistent use of condoms (or other barriers), and reducing the highest-risk sexual practices, such as condomless receptive anal sex. Understanding the context of patients' lives and behavior may help inform counseling and care. For example, patients who exchange sex for items such as food or shelter may not be empowered to request that their partners use condoms; for these patients, a focus on biomedical prevention strategies, such as PrEP, may be more appropriate.



Biomedical prevention strategies

Biomedical prevention strategies consist of vaccinations against sexually transmitted pathogens and the use of antiretroviral medications to prevent HIV acquisition or transmission; all of these strategies can be incorporated into primary care.

HPV vaccine

Vaccination against HPV is recommended for all adolescents and for adults up to age 26 who were not vaccinated as adolescents. The HPV vaccination is FDA-approved for adults up to age 45.

Hepatitis A and B vaccines

MSM should be vaccinated against hepatitis A and hepatitis B. Hepatitis A vaccination may also be beneficial for others who engage in anal sex, and hepatitis B vaccination is recommended for all who have multiple sexual partners.¹³ Vaccinations against other STIs, such as syphilis, gonorrhea, chlamydia, are not currently available

PrEP

PrEP refers to the use of antiretroviral medication to prevent HIV acquisition by people who are HIV-uninfected but at high risk. Currently, only one drug, once daily oral tenofovir disoproxil fumarate-emtricitabine, is FDA-approved for PrEP in the United States. When taken as prescribed, PrEP is more than 90% effective at preventing HIV.¹⁴ Candidates for PrEP require baseline testing to assess for pre-existing HIV and hepatitis B infection and to confirm normal renal function. While on the medication, periodic HIV testing, STI screening, and measurement of kidney function are mandatory. Guidelines for PrEP prescribing are available in the Resources on the next page.

Post-exposure prophylaxis (PEP)

PEP refers to the use of antiretroviral medications for 28 days following a discrete exposure to HIV. To maximize effectiveness, PEP should be started as soon as possible after the exposure, and within 72 hours at most. People taking PrEP generally do not require PEP after an HIV exposure. Providers should discuss PEP with patients who have an increased risk of HIV to help them devise a plan to access the medications in case of an exposure.

Virologic suppression through engagement in care

Antiretroviral therapy that achieves virologic suppression essentially eliminates the possibility that a person living with HIV will transmit the virus to a sexual partner, even when a condom is not used.¹⁵ Thus, diagnosing HIV and helping patients initiate and adhere to antiretroviral therapy are some of the most important steps clinicians can take to address the HIV epidemic. Patients whose sexual partners are living with HIV but are virologically suppressed on antiretroviral therapy sometimes choose to forgo condoms based on these data, which may increase their likelihood of contracting STIs such as gonorrhea, chlamydia, and syphilis. A detailed sexual history is necessary to understand if these patients are at risk for non-HIV STIs and to counsel them accordingly. Some HIV-uninfected patients who are in relationships with HIV-infected but virologically suppressed partners may also benefit from PrEP, if they have other sexual partners.

Summary

HIV disproportionately burdens some LGBTQ groups, and rates of non-HIV STIs are increasing, particularly among MSM. Clinicians can address these epidemics by incorporating culturally appropriate, inclusive sexual histories into routine care and by providing counseling and preventive care that are evidence-based and guided by the sexual history. PrEP is highly effective at preventing HIV, though only a minority of PrEP candidates are currently receiving the medication. By incorporating PrEP into routine clinical care for LGBTQ patients at increased risk of HIV infection, providers can help end the HIV epidemic in the United States.

Guidelines

- 2015 Sexually Transmitted Disease Treatment Guidelines. Centers for Disease Control and Prevention; 2015. Available at: <https://www.cdc.gov/std/tg2015/default.htm>.
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- CDC Guidelines for PrEP Prescribing: www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guide-lines-2017.pdf.
- CDC Guidelines on PEP: www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf.

National LGBT Health Education Center: Selected Resources

Videos and Webinars: www.lgbthealtheducation.org/lgbt-education/webinars/

- Sexual Health among Transgender People
- Understanding and Assessing the Sexual Health of Transgender Patients
- What's New in STI Epidemiology, Prevention, and Treatment for Men Who Have Sex with Men (MSM)?
- HIV and STI Prevention among LGBTQ People
- Delivering HIV Prevention and Care to Transgender People
- Syphilis among Men Who Have Sex with Men: Clinical Care and Public Health Reporting
- Screening and Testing for Sexually Transmitted Infections in Gay, Bisexual and Other Men Who Have Sex with Men
- If You Have It, Check It: Overcoming Barriers to Cervical Cancer Screening with Patients on the Female-to-Male Transgender Spectrum
- Pre-Exposure Prophylaxis (PrEP) for HIV: The Basics and Beyond
- Black MSM and PrEP: Challenges and Opportunities
- PrEP and Transgender Communities: Evidence Informed Practices

Publications: www.lgbthealtheducation.org/lgbt-education/publications/

- Glossary of LGBT Terms for Health Care Teams
- Learning to Address Implicit Bias Towards LGBTQ Patients: Case Scenarios
- Pathways to Parenthood for LGBT People
- Ten Things: Creating Inclusive Health Care Environments for LGBT People
- PrEP Action Kit (focuses on LGBTQ people): www.lgbthealtheducation.org/prep-action-kit/.

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Acknowledgements

Written by Kevin L. Ard, MD, MPH, in collaboration with the National LGBT Health Education Center.

This resource is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling \$449,994 with 0 percent financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit [HRSA.gov](https://www.hrsa.gov).