

Emerging models of clinical services for men who have sex with men: focused versus comprehensive approaches

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Abstract. By the early 1970s, it was increasingly recognised that men who have sex with men (MSM) were at risk for specific sexually transmissible infections (STI), and clinician awareness regarding MSM STI grew significantly after the AIDS epidemic was first recognised in 1981. In many urban centres in the USA and other resource-rich countries, the development of clinical infrastructure to address the AIDS epidemic led to the creation of clinics that provided services for large numbers of MSM. During the same time period, other health centres were created that were community-focused, providing comprehensive behavioural health and medical services for all sexual and gender minority patients. Over the next few years, multiple models for MSM sexual health will evolve, ranging from centres that embed STI care in primary care, to more focused centres that can use new technology to provide an efficient assessment for at-risk MSM desiring quick screening services.

Received 10 June 2016, accepted 28 June 2016, published online 29 August 2016

Over the past few decades, sexual health services for men who have sex with men (MSM) have undergone some remarkable changes. Initially, sexual health services were nested within traditional genitourinary medicine clinics. In many urban centres in the USA and in other developed countries, these centres were not necessarily perceived as particularly gay-friendly, but by the late 1960s, researchers noted that there were discreet populations of MSM whose sexual practices put them at risk for a unique array of sexually transmissible infections (STI). Early reports of STI among MSM included ‘gay bowel syndrome’ associated with oral-anal contact (rimming) as well as some of the first descriptions of sexually transmitted hepatitis A and hepatitis B.¹ It was the advent of the AIDS epidemic that led to an increased awareness of the role that male homosexual behaviour could have in transmitting a serious STI.

At the same time that the AIDS epidemic highlighted the potential sexual transmission of HIV, it also highlighted the fact that the individuals who were manifesting new STI including HIV were full human (i.e. not just vectors of infection) beings who warranted “culturally competent care.”² This term means that providers would be sensitised to the different lived experiences of sexual and gender minority people, who often experience stigma from expressing their identities, in addition to understanding the different behaviours (e.g. anal intercourse) that might place these patients at increased risk for specific infections. During the same period as the increased awareness of STI evolved, community groups across the USA developed locally relevant programs for MSM and other sexual and gender minority populations. Fenway Health was founded in 1971, not as a gay clinic, but as a neighbourhood health centre that had a substantial number of administrators, clinicians and patients

who were sexual and gender minority individuals.³ Because of a vacuum in many cities in developing a comprehensive response to the AIDS epidemic, health centres like Fenway Health filled in the void, having to scale up rapidly to deal with the multiple social and behavioural aspects of STIs (Box 1). Other clinics across the United States that developed specifically to address concerns of MSM and other lesbian, gay, bisexual and transgender (LGBT) individuals included Howard Brown in Chicago, Whitman–Walker in Washington DC, Callen–Lorde in New York City, the Montrose clinic (now known as ‘Legacy’) in Houston, Chase Brexton in Baltimore and the Los Angeles Gay and Lesbian Center in California. MSM- and LGBT-specific clinics have developed in other countries as well, including cities in Canada, Western Europe and Australia.

In the 1980s, in a setting of death and destruction from an untreatable epidemic, STI rates in MSM declined substantially.⁴ With the advent of highly active antiretroviral therapy (HAART) in the mid-1990s, and with HIV becoming a more chronic manageable infection, the decrease in the number of new STI plateaued. The increasing political enfranchisement of LGBT people in many industrialised democracies, and the recognition that they needed other health services beyond genitourinary medicine, led centres like Fenway Health, to expand the array of clinical services offered (Box 2). The Fenway model was established to embed STI and HIV care in primary care, and to service all local residents, with a specialisation in LGBT health services (Figs 1, 2).

The growing awareness that with medication, HIV was not a death sentence, and more recently, the availability of pre-exposure prophylaxis (PrEP), has changed the norms away from condoms and other safer sex means to prevent mucosal contact

Box 1. Multifactorial reasons for increased HIV and sexually transmissible infection (STI) risk for men who have sex with men (MSM)

- **Individual behaviour** (No. of partners/time)
- **Biology**
 - Anal intercourse ↑susceptibility to HIV, other STI
 - Role versatility: receptive can be insertive, ↑ transmission efficiency
 - STI ↑ HIV transmission and acquisition, and vice-versa
 - Other sexual behaviours are associated with other STI (e.g. oral sex and syphilis)
- **Networks**
 - HIV/STI per contact risk ↑in high prevalence settings
 - Assortative mixing in sub-groups (e.g. racial/ethnic minorities)
 - Sexualised venues (e.g. bathhouses, social media, sex work)
- **Structural/Societal**
 - Homophobia, bullying leads to early developmental stress, depression, lack of self-efficacy and ↑risk
 - Criminalisation and discrimination in healthcare settings impede disclosure and receipt of timely health services

Box 2. Fenway Health – services provided

- Primary health care
- Speciality care (HIV/AIDS, sexually transmissible infections, obstetrics, gynaecology, podiatry, dermatology and nutritional counselling)
- Behavioural health and addiction services
- Dental care
- Eye care
- Full-service pharmacy
- Complementary/alternative therapies (chiropractic, massage and acupuncture)
- HIV counselling & testing
- Health promotion and community outreach
- Violence prevention and recovery services
- Family and parenting services, including alternative insemination
- Community health education

between MSM.^{5,6} For example, at Fenway Health, every year since 2000, the number of new bacterial STI has continued to increase,⁷ with more than 1000 being diagnosed in 2015. At the same time, PrEP starts increased dramatically, and rates of virological suppression for HIV-infected MSM on HAART approached 90%.⁸ Although almost half of new syphilis infections diagnosed at Fenway Health were among HIV-infected individuals, who constitute less than 20% of the at-risk MSM population in the greater Boston area, most of the individuals presenting with urethral and rectal gonorrhoea are HIV uninfected.

Thus, one may speculate that in an era of treatment as prevention and PrEP, specialised sexual disease clinics for MSM will be even more important by the year 2020. Both MSM and LGBT specialised health centres may be seen as models of service delivery that are highly responsive to

populations that are sexually active by using a sexual harm reduction model that is, increasing the ease and frequency of STI screening in order to minimise the number of people in the community who might be exposed to some of these infections. For example, in downtown London, the Dean Street Express (<http://www.chelwest.nhs.uk/services/hiv-sexual-health/clinics/dean-street-express>; Fig. 3) has created a user-friendly interface in which individuals can drop in, fill out their sexual histories on a tablet PC interface, be directed by a video into a private stall to self-collect specimens for STD screening, have those delivered through a pneumatic tube to a central laboratory, and have a very rapid turnaround time. Individuals can visit a local café while they wait for their results to be quickly text messaged to them. This model has a great deal of merit because of the elimination of many common barriers to routine STI screening that many MSM may anticipate, such as having to schedule

appointments well in advance in busy centres and reducing the likelihood of coming in contact with staff that may appear judgmental and homophobic.

In contrast, this 'one-stop shopping' low impact model needs to be complemented by other insights that have emerged over the course of the last few decades of evolving thinking about the health of MSM. A substantial body of knowledge is now available throughout the world that suggests that some of the reasons why HIV and STDs are quite prevalent among MSM include the high HIV and STD transmission efficiency of specific sexual practices (e.g. receptive anal intercourse), as well as the unique role versatility of MSM (i.e. being able to be both a receptive and insertive partner) (Box 1).⁹ For specific subgroups of MSM, such as racial and ethnic minorities, assortative mixing may also potentiate HIV and STD prevalence; that is, amplifying incident infections because of a limited partner pool if MSM who are from racial and ethnic minority communities are more likely to choose partners from within their community.¹⁰ However, there are other social, structural and behaviour reasons that also potentiate HIV and

STD transmission among MSM. Young MSM grow up in environments that very often may be non-affirming, and they may internalise societal homophobia, resulting in a sense of helplessness and depression, which may lead to attempts to cope and self-medicate through the use of disinhibiting substances.¹¹ Thus, programs that are scaled up just to efficiently provide STI screening and treatment may not be addressing some of the important syndemic conditions that may be leading to more efficient HIV and STI spread. Thus, for the future of MSM health, a broader view of sexual health must include not just the detection of specific organisms in their treatment, but also addressing the psychosocial factors that may be quite prevalent among MSM. Thus, for example, at Fenway Health, of more than 135 000 patient visits in 2015, a substantial number of visits were to see a behavioural health specialist. To be responsive to the diverse behavioural health needs of MSM, the Fenway Health menu of mental health programs range includes psychiatry and psychopharmacology, individualised counselling and support groups, and the use of complementary approaches such as acupuncture for substance use detoxification, massage and chiropractic care.

In recognition of addressing MSM as whole individuals, a comprehensive community-centred primary care approach might lead to additional service utilisation. Thus, at Fenway Health, in addition to providing primary medical care for the diagnosis of other concomitant health conditions besides HIV and STI, dental services and optometry are available in-house, as well as access to an in-house pharmacy. This concept of 'one-stop shopping' is intended to facilitate engagement with comprehensive health services. The premise is that MSM have health concerns that extend beyond HIV and STI screening, and that rates of routine screening will increase if they are embedded in a more holistic care model.

In addition, as we look towards 2020 and beyond, many of the original generation of MSM who came out in the Stonewall generation and survived the AIDS epidemic will be increasingly aging.¹² This does not mean that they will be at the end of an age of sexual functioning, and therefore ongoing HIV and STI screening will not be needed, but they will also be at increased risk for other concomitant health conditions ranging from

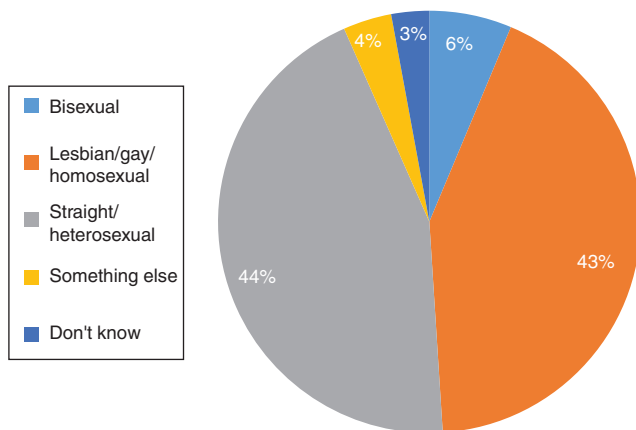


Fig. 1. Self-reported sexual orientation of patients accessing medical care at Fenway Health in FY2014 ($n = 16\,303$ who self-reported; 3845 did not report sexual orientation).

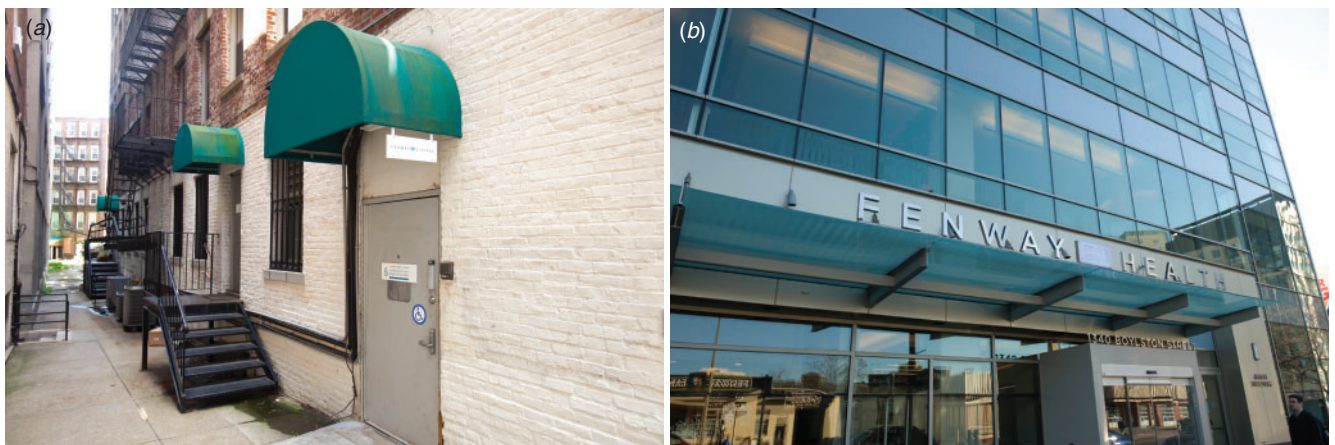


Fig. 2. Fenway Health, Boston, external views circa (a) 1985 and (b) 2015. Photo credit to Marilyn Humphries.



Fig. 3. Dean Street Express, London, 2015.

hypertension to diabetes. Individuals who may not live in dominant culture heterosexual families may require additional supportive services from their primary health care facility to ensure that they receive home health services if they have limitations in mobility and/or cognitive impairment.

As we look to 2020, it is also important to note more recent conversations about gender and gender identity. As generations of people come up in an age where gender is recognised as more fluid and less dichotomous, the concept of 'men who have sex with men' will need to evolve to include assessments that include sex at birth and anatomy. This further demonstrates the need for thoroughly gathering information about sexual orientation and gender identity among patient populations. Increasingly, MSM and other sexual and gender minority populations are achieving civil equality in their societies.

Access to 'gay marriage' does not necessarily guarantee monogamy (which is also true for heterosexuals), but may improve other aspects of behavioural health.¹³ In this context, MSM sexual health programs will have to think about the best ways to offer sexual health screenings for couples and to provide the appropriate kinds of counselling that may ensue when one partner may be found to have developed an incident STI. The challenges of partner notification are not new, but the nuances may be evolving when screening married MSM couples.

Thus, the models for providing the best levels of services for MSM are evolving in diverse ways. On one hand, new technologies (e.g. computer-assisted self-assessment and education, rapid and high throughput nucleic acid amplification tests) can facilitate models like the Dean Street Express, which can allow individuals who want to be assured

that they have not acquired or will not be transmitting a STI an efficient and effective means of rapid diagnosis, with limited ongoing relationships with the centre. In contrast, as MSM increasingly become fully enfranchised citizens of societies, the development of health system structures that are capable of providing comprehensive STI screening, as well as counselling and preventive services, will be increasingly important. The co-location of medical and clinical services will create more incentives for individuals to engage with their local healthcare system. Because the provision of some of these services may require the use of a variety of payment sources, it will be important for healthcare facilities that provide comprehensive sexual health services for MSM to also have programs in place to allow for the subsidisation of services that may not be fully funded by national insurance plans. In the USA, because of the variability of insurance sources, the use of paraprofessional health system navigators has become a very efficient way to ensure that individuals who are trying to access multiple services do not fall between the cracks.

Other key functions of sexual health clinics for MSM remain. Because of the increased concentration of MSM in many urban areas, clinics that particularly focus on the provision of comprehensive sexual health services for MSM can continue to serve very important functions as centres to train and educate the next generation of healthcare providers, so that they are competent in the provision of sexual health services for MSM. Sexual and gender minority health has become an important area of specialisation for primary care clinicians, who need to learn about the differences in the epidemiology of diverse health conditions of LGBT patients, including, but not limited to STI, as well as the reasons for their health disparities and challenges to accessing primary care services. In order to ensure that primary care providers outside of urban epicentres have an opportunity to learn about the best practices for the care of sexual and gender minority patients, the American College of Physicians has published 'The Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health' (Fig. 4).¹⁴ Additional training resources are available through the website www.lgbthealtheducation.org, developed by Fenway Health's National Center for LGBT Health Education, funded by the USA government.

Lastly, programs that focus on MSM STI have an important role in assisting public health authorities in surveillance for emerging trends, ranging from increases in the prevalence of specific conditions (e.g. syphilis) to associations of newly recognised pathogens in subgroups of MSM (e.g. specific websites), to the detection of the spread of drug-resistant strains across the world. Because of the global genepool in which we live, we never know when or where the next epidemic may arise. If the epidemic is transmitted through sexual contact, it will be important to have centres that have the expertise to provide the diagnostic services and public health surveillance intelligence so that new epidemics can be rapidly identified and addressed. Certainly in the past few years, centres that have focused on MSM sexual health initially were the places that recognised the advent of the AIDS epidemic and, subsequently, outbreaks of Lymphogranuloma venereum and sexually transmitted hepatitis C. Moreover, in an era where some of the STI microbes have become increasingly resistant,

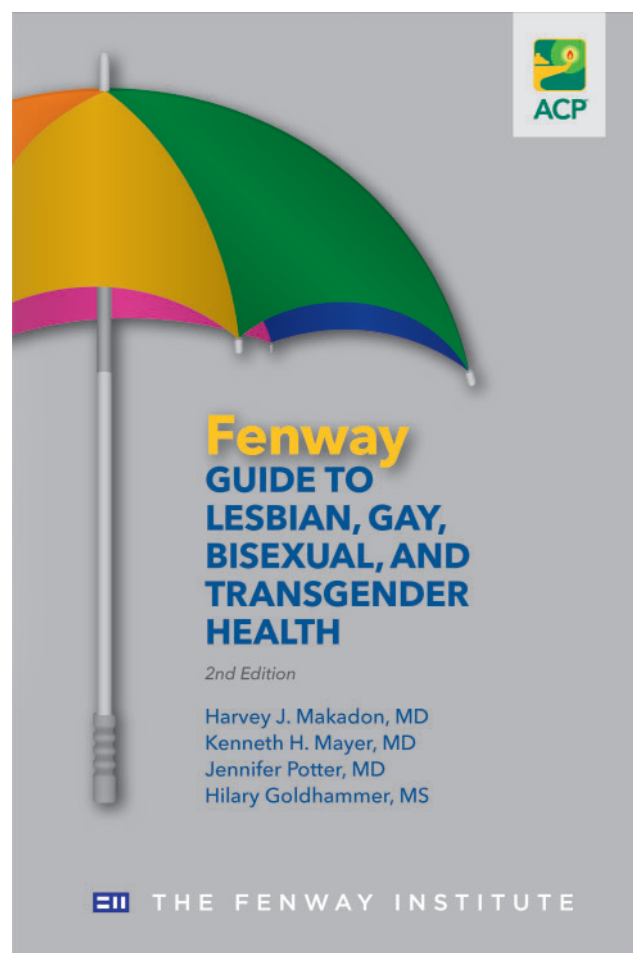


Fig. 4. The Fenway Guide to lesbian, gay, bisexual and transgender (LGBT) health.

the residual functions of public health surveillance in these clinics to detect multidrug resistance in gonorrhoea or other organisms will remain increasingly important.

Post 2020, it is hoped that major metropolitan areas can support these specialised clinics that can both offer comprehensive services for individuals who prefer 'one-stop shopping' and have multiple health needs, as well as efficient models that utilise newer technologies (i.e. the 'Express' models) in order to ensure that individuals who may be transient or who may not want to fully engage with the healthcare system, have access to effective services for the provision of comprehensive sexual health care.

Conflicts of interest

None declared.

Acknowledgements

The assistance of Mary Childs in the preparation of this manuscript is greatly appreciated.

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