

# **Men Who Have Sex with Men (MSM)/ Women Who Have Sex with Women (WSW)**

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Definition .....	1
Epidemiology .....	1
Prevention and Control .....	2
Evaluation .....	4
Specimen Collection and Laboratory Diagnosis .....	5
Management and Treatment .....	5
Reporting and Partner Notification .....	5
Follow-up .....	6

# MEN WHO HAVE SEX WITH MEN (MSM) / WOMEN WHO HAVE SEX WITH WOMEN (WSW)

## Definition

Men who have sex with men (MSM) may have sex with men exclusively, or with both men and women, and may self-identify as gay, bisexual or heterosexual.

Women who have sex with women (WSW) may have sex with women exclusively, or with both women and men, and may self-identify as lesbian, bisexual or heterosexual.

## Epidemiology

Following a decline in the prevalence of reportable sexually transmitted infections (STIs) among MSM beginning in the 1980s, the incidence of syphilis, gonorrhea, chlamydia, genital herpes, hepatitis A virus (HAV), hepatitis B virus (HBV) and HIV infections has risen among MSM in Canada and internationally since the mid-1990s.<sup>1–12</sup> Recent outbreaks of syphilis among MSM have been reported,<sup>2,3,13,14</sup> with a large proportion of cases co-infected with HIV. Similarly, recent outbreaks of lymphogranuloma venereum (LGV) have been reported internationally<sup>15–20</sup> and in Canada<sup>21</sup> among MSM, with a high degree of HIV co-infection. Co-infection is of particular concern, given that syphilis and other STIs can increase the likelihood of HIV transmission and acquisition.<sup>22–25</sup>

Rising rates of STIs among MSM are associated with increases in unsafe sexual practices,<sup>26</sup> including unprotected anal intercourse (otherwise known as bare-backing);<sup>12,27–31</sup> an increase in the number of sex partners;<sup>1,12</sup> partner-finding on the Internet<sup>32–37</sup>; other anonymous partnering venues (e.g., bathhouses);<sup>1,38</sup> recreational and non-recreational drug use;<sup>1,27,39–43</sup> and unprotected oral sex.<sup>1</sup> Rates of unprotected anal intercourse have increased among MSM of all ages, and between HIV serodiscordant partners.<sup>28,31,44</sup>

Many explanations have been proposed for the recent increase in risky sexual practices among MSM, including fatigue with safer-sex messages and reduced fear of acquiring HIV due to optimism about new HIV treatments,<sup>45,46</sup> although the correlation with treatment optimism has not been shown consistently.<sup>47</sup> The increase in unsafe sexual practices among HIV-infected MSM has been attributed in part to the increasing proportion of HIV-infected MSM who feel healthy, are living longer and are therefore having sex more often and with more partners. Lack of knowledge of their own and their partners' STI status, including HIV, is also a concern; for example, almost 27% of HIV-positive men in the *Ontario Men's Survey* were unaware of their HIV status.<sup>26</sup>

Common recreational drugs used at bathhouses, raves or circuit parties include alcohol, methamphetamine ("crystal meth"), methylenedioxymethamphetamine (MDMA or "ecstasy"), ketamine ("special K"), gamma hydroxybutyrate (GHB), volatile nitrites (poppers) and cocaine (see *Substance Use* chapter). The reduction in inhibition that accompanies the use of these drugs can increase the likelihood of multiple sex partners and unprotected sex, and may be partnered with the use of sildenafil citrate (Viagra™), vardenafil (Levitra™) or tadalafil (Cialis™) to counteract the erectile-dysfunction side effect of some of them. The use of sildenafil among MSM has been linked to an increased risk for multiple sexual partners and STI acquisition.<sup>48,49</sup>

Sexually transmitted epidemics of enteric infections such as *Salmonella enterica* serotype typhi (typhoid fever)<sup>50</sup> and *Campylobacter jejuni* subsp. *jejuni*,<sup>51</sup> as well as sexual transmission of human herpes virus<sup>8,52</sup> have been documented among MSM populations in Canada and the United States.

There are very few data on rates of STIs among WSW, although studies have consistently found higher rates of STIs — specifically human papillomavirus (HPV), genital warts, HIV, syphilis and genital ulcer disease — among heterosexual and bisexual women than among women who have sex with women exclusively.<sup>53–55</sup> Although STI transmission among WSW is strongly correlated with sexual contact with male partners, sexual transmission of HIV, syphilis, HPV, herpes simplex virus types 1 and 2 (HSV-1 and -2), *Trichomonas vaginalis*, *Chlamydia trachomatis* and HAV have been reported in WSW with no history of a male partner.<sup>56–61</sup> Higher rates of bacterial vaginosis and hepatitis C (HCV) have been reported for WSW than for women with male sex partners only.<sup>55,62,63</sup> The few studies exploring STI risk behaviours among WSW have demonstrated higher rates of sexual contact with homosexual/bisexual men;<sup>55,64,65</sup> sex with HIV-infected partners;<sup>64</sup> injection drug use;<sup>54,55,64,66</sup> sex for money or drugs;<sup>54,64,66</sup> and a greater number of recent partners<sup>64</sup> among WSW compared to exclusively heterosexual women.

## Prevention and Control

Prevention counselling with MSM and WSW, as with all sexually active populations, should emphasize personal risk and risk behaviours, as well as the initiation and maintenance of risk-reduction activities with a client-centred focus. It is important for health care providers to avoid making assumptions about involvement in risky behaviours, including drug use, based on sexual orientation. It is also important that health professionals accurately communicate the risks associated with various sex acts to their sexually active patient, including the risk of transmission via oral sex (i.e., although the risk of STI transmission is lower via oral sex than vaginal or anal sex, many STIs, including syphilis, chlamydia, gonorrhoea, herpes and HIV, can be transmitted through unprotected oral sex).

Risk-reduction strategies to include in discussions with MSM and WSW, and all sexually active patients, include the following (see *Primary Care and Sexually Transmitted Infections* and *Human Immunodeficiency Virus Infections* chapters for more information on safer-sex counselling and HIV-specific counselling):

- Avoiding or minimizing unprotected anal, vaginal, oral and oral-anal intercourse; in addition to intercourse, minimize other sexual activities involving exchange of bodily fluids (i.e., sharing of sex toys), which also carry risk for STI transmission.
- Ensuring consistent and correct use of condoms for vaginal intercourse and both insertive and receptive anal intercourse.
- Ensuring use of barrier protection for oral sex.
- Avoiding or minimizing sexual encounters with multiple and anonymous partners, as well as the use of recreational drugs in conjunction with sex.
- Regular testing for STIs if engaging in unprotected or risky sexual activity.

- Negotiating safety in sexual encounters, including disclosure of STI status to partners and learning partners' STI status; it should be noted, however, that serostatus disclosures may or may not be accurate, and that safer-sex practices (i.e., condom use or non-penetrative acts) provide the best protection against STIs in a sexual encounter.
- Avoiding the use of products containing nonoxynol-9 (N-9) during intercourse, given the safety and efficacy concerns regarding its use (see *Primary Care and Sexually Transmitted Infections* chapter for more information on N-9). N-9 found on spermicidally lubricated condoms may provide added protection against pregnancy, but it does not effectively protect against infection with HIV or other STIs and may irritate the genital mucosal lining, facilitating their transmission; however, a condom lubricated with N-9 is better than no condom at all.
- Receiving vaccination for both HBV and HAV; this should be offered to all MSM, given their increased risk of infection<sup>67,68</sup> and poor vaccination coverage;<sup>69</sup> the first dose can be given while waiting for serological test results (if performed), as immunization is not harmful for previously vaccinated or infected persons (see *Hepatitis B Virus Infections* chapter for more information on HBV vaccination and preimmunization screening).\*
- For WSW, undergoing regular cervical screening for dysplasia and/or HPV infection.

**Note:**

\* Preimmunization testing for immunity against HAV should be considered for populations with the potential for higher levels of pre-existing immunity (i.e., older Canadians and people from HAV-endemic areas). Routine preimmunization serologic screening for HBsAg, anti-HBs or anti-HBc is recommended for people at high risk of having been infected, but is not practical for universal immunization programs.<sup>70</sup>

Recognizing that MSM and WSW are diverse populations and that reasons for unsafe sexual practices will vary across individuals and subcultures, prevention messages should be tailored to the individual in question and should allow for discussion of realistic safer-sex goals. To be most effective, safer-sex messaging should not be a discussion of sexual risk alone, but one that takes into account the broader context of sexual health influences, including intimacy; sexuality and arousal; drugs and alcohol; mental health, including self-esteem and self-worth; abuse and coercion; and sexual identity.<sup>71,72</sup> Using a motivational interviewing approach for prevention counselling can be effective in promoting harm-reduction behaviours (see *Primary Care and Sexually Transmitted Infections* chapter for more information on motivational interviewing).

## Evaluation

Prior experiences of MSM and WSW with discrimination, homophobia and heterosexism may have an effect on health care-seeking behaviour and disclosure of sexual behaviour in consultations.<sup>73,74</sup> **In every patient encounter, it is important to avoid the assumption of heterosexuality.** Taking a basic sexual history for all sexually active patients is important for establishing the following:

- Presence of opposite-sex and same-sex activity.
- Range and frequency of sexual practices.
- Level of risk for specific STIs.

Self-identified sexual identity is not an accurate predictor of behaviour;<sup>75</sup> it is necessary to ask specific questions about the gender of sexual partners when taking a sexual history. Using gender-neutral terms such as “partner” can help to create an environment that is comfortable for disclosure.<sup>73</sup> **The best approach to obtain a sexual history is to begin with open-ended, non-judgmental questions regarding broad categories of sexual behaviour and progressing to specific sexual practices.**

Asking, “Do you have sex with men, with women, or with both?” may be a useful question during the sexual history to assess gender of sexual partners (see *Primary Care and Sexually Transmitted Infections* chapter for more information on taking a sexual history).

### **Specific sexual practices that are associated with increased risk of STIs and should be assessed for with all sexually active patients include the following:**

- Receptive (passive) and insertive (active) anogenital intercourse.
- Oral-anal intercourse (anilingus).
- Unprotected sexual activity (oral, anal, or genital).
- Sharing of sex toys.
- Rectal douching in association with receptive anogenital intercourse.
- Receptive manual-anal intercourse (insertion of finger or fist in anus of partner).
- Anonymous partnering and use of anonymous partnering venues (e.g., bathhouses, Internet, raves, circuit parties).
- Substance use accompanying sex.
- Intravenous drug use (IDU) and other substance use.

Based on results from the risk assessment, the following screening should be considered for men who have had unprotected sex with another man in the preceding year:

- Routine STI screening at all potential sites of infection (chlamydia, gonorrhoea, syphilis), HIV serology (unless known to be seropositive) and HBV and HAV serology (if not previously immunized or known to be immune) (see *Hepatitis B Virus Infections* chapter for more information on HBV screening).
- Although asymptomatic screening for HSV and HPV is not currently recommended, new information may alter these recommendations. Studies are ongoing assessing whether screening in certain situations is cost-beneficial.

Assessment for STI symptoms including dysuria, anorectal symptoms (e.g., pain, discharge, bleeding, pruritus), urethral discharge, genital ulcers or lesions, and skin rash should be completed and appropriate diagnostic testing conducted if symptoms are present.

In addition to careful genital and targeted extragenital examination, a physical examination for MSM may include the following (see *Primary Care* and *Sexually Transmitted Infections* chapter for more information on physical examination):

- Examination of lymph nodes, skin, sclera, oral cavity, pharynx and perianal region.
- Anoscopy or proctoscopy for symptomatic MSM who are the receptive partner for anogenital sex.

**Misconceptions about the STI risk and sexual practices of WSW may negatively impact the sexual history and screening performed for this group of women. STI-screening recommendations for WSW should be based on a detailed risk assessment, not on assumptions of low-risk sexual behaviours** (see *Primary Care* and *Sexually Transmitted Infections* chapter). WSW, including those with no history of a male sexual partner, are at risk for cervical abnormalities<sup>55,58</sup> and should be encouraged to receive regular cervical screening for dysplasia and/or HPV infection.

## Specimen Collection and Lab Diagnosis

As for all patients, while the choice of STI screening tests is based on the results of the sexual history (as described above), the choice of STI diagnostic tests should be based on the differential diagnosis of the presenting syndrome (e.g., proctitis). The following recommendations apply (see *Laboratory Diagnosis of Sexually Transmitted Infections* chapter for specific information on specimen collection):

- Anorectal gonorrhea and chlamydia cultures, if engaging in unprotected anal intercourse.
- Pharyngeal gonorrhea cultures, if performing unprotected oral sex.
- Laboratory testing for pathogens not usually associated with STIs (i.e., HAV, enteric organisms) but that can cause sexually transmitted proctitis, proctocolitis and enteritis may be indicated based on risk assessment and symptoms (e.g., examination of stool for ova and parasites).

### Note:

Although culture remains the recommended test method for assessing pharyngeal or rectal infections, limited studies suggest a potential role for nucleic acid amplification testing for detection of pharyngeal gonorrhea<sup>76</sup> and rectal chlamydia;<sup>77</sup> there are promising data on the use of rectal and oral swabs for *C. trachomatis* and *N. gonorrhoeae* tested by NAATs and current clinical trials are underway through the U.S. National Institutes of Health.

## Management and Treatment

- Same as for all patients.

- It is important to be aware of the potential stress associated with the “coming-out” process and to be knowledgeable about gay- and lesbian-specific support groups and community networks for referral as needed.

## Reporting and Partner Notification

- Same as for all patients.
- Anonymous partnering presents a challenge for partner notification, making it difficult, if not impossible, to contact and treat partners who have been exposed to an STI.

## Follow-up

- WSW should be encouraged to undergo regular cervical screening for dysplasia and/or HPV infection.
- Patients whose history reveals unsafe sexual behaviours should be encouraged to engage in safer-sex and harm-reduction behaviours, and to be screened frequently for STIs (at least yearly) (see *Primary Care and Sexually Transmitted Infections* chapter).
- Patients who receive their first dose of HBV or HAV vaccination should be reminded to return to complete the vaccination series.