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Mainstreaming HIV services for men who have sex with men: the role of general practitioners

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MAINSTREAMING HIV SERVICES FOR MEN WHO HAVE SEX WITH MEN: THE ROLE OF GENERAL PRACTITIONERS

General practitioners (GPs) and other primary care doctors around the world have a strong potential for providing quality HIV prevention, testing and treatment for men who have sex with men, as advocated by the recent WHO guideline.[1] As the HIV epidemic becomes more focused on chronic disease care in many parts of the world, a number of primary care issues come to the forefront of clinical HIV service delivery. GPs have advantages in providing HIV services because of their position as trusted, community-based, long-term advocates for their patients. The training and capacity of GPs to engage marginalised groups of people increase the like-lihood that GPs can provide MSM with needed, high-quality clinical care.

The health problems and health-seeking behaviours of MSM are fundamentally no different from other men seen by GPs. Management of common problems such as respiratory tract infections and hypertension is the same as for other men. Yet MSM may also have an increased risk of HIV, sexually transmitted infections including human papillomavirus, mental health problems[23] and drug and alcohol use.[3] Recent research on sexually transmitted Hepatitis C infection, especially among HIV-infected MSM, has been described[4] and individuals who have a history of anal sex are more likely to acquire anal dysplasia.[5] Among young MSM, bullying and associated psychological stress are important health issues that require careful consideration.

An expanding evidence base demonstrates the potential for GPs to directly provide HIV services. A systematic review suggests that GPs are effective in HIV counselling, testing and treatment when compared to specialty care alone.[6] Cost-effectiveness studies favour a primary care HIV service delivery model.[7] At the same time, there are fewer data on GP provision of contact tracing and HIV prevention, two activities that are emphasised in specialist HIV clinics. Further training and support will be important for making widespread

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GP-directed HIV services successful, especially in places where these models are not well established.

MSM, like other patients, need GPs they can trust in order to forge a long-term relationship with their chosen doctor. GPs serving MSM need to be open-minded to gay lifestyles or at least respond neutrally to issues raised about sexuality and other aspects of MSM culture. Especially in cultures where homophobia is deeply engrained, cultivating this clinical environment may be challenging and requires strong advocacy and new norms. But this should not distract from the importance of providing high-quality clinical services to all individuals, regardless of sexual orientation. MSM perceptions of discrimination and stigma, often founded in personal experiences, can powerfully disrupt medication adherence and challenge doctor-patient communication.[8] Misunderstandings and unspoken assumptions of sexuality by GPs can create gaps in care.

To bridge this service gap, there are several potential ways to move forward a primary care HIV service model for MSM patients. At initial patient visits GPs could clearly articulate their commitment to non-discrimination and confidentiality. Waiting rooms including images of same sex norms could help create a physical environment more conducive to the development of trusting relationships that are independent of sexual orientation or behaviour. Gender-neutral language could be used on routine intake forms to encourage individuals to feel safe in disclosing their sexual identity and behaviours. A complete sexual history without assumptions about engagement in high-risk behaviours is essential for good continuing clinical management. Although these are small steps, they could go a long way towards better serving MSM patients in GP clinic settings.

There are surmountable barriers to expanding a GP-focused HIV service delivery model for MSM. Some GPs may fear that having a clinical environment more conducive to MSM discourages heterosexual clients. However, experience from Australia where GPs routinely see HIV-infected patients suggests that this has not occurred and that there are some GPs who have low HIV caseloads while others have higher caseloads. Differences in case-loads can present challenges for streamlined training systems and ‘one-size-fits-all’ approaches to clinician issues. This challenge is being overcome, for example, by pairing more experienced HIV clinicians with less experienced HIV clinicians in Australia.[9] In addition, developing GP capacity to evaluate HIV-infected MSM may be challenging in low and middle income countries where gay culture is less acceptable and may have fewer gay-friendly doctors. Developing medical curricula and other training materials specifically for low and middle income country contexts may be useful to overcome these obstacles.

To date, operational research on optimal health systems for serving MSM has been limited. Large variations in estimates of the absolute size of MSM communities, and the fact that many MSM hide their identity, make study design at single sites challenging. Indeed, the field of operational research focused on sexual health services is still emerging. Operational research could help determine organisational and financial models best suited to serve MSM and further research in this area to address barriers and better understand the advantages and disadvantages of primary HIV healthcare undertaken by GPs is much needed.

Providing high-quality HIV clinical services to specifically meet the clinical needs of MSM is no small task. Like all patients, MSM require care, commitment and compassion from their GPs. But beyond the typical mandate of the doctor-patient relationship, awareness of the more specific risks and needs of MSM is critical. Guidelines and recommendations for HIV/sexually transmitted infections screening among MSM[10][11] exist, but their implementation is far from widespread.[11] The landscape of HIV prevention and

management is fast changing which provides an opportunity for GPs to play an expanded and significant role in MSM HIV care as well as other aspects of MSM clinical care.

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Key points

▲ General practitioners (GPs) and other primary care doctors have a strong potential for providing quality HIV and other clinical services for men who have sex with men (MSM).

▲ The health problems and well-being of MSM are fundamentally no different from other men, but there are specific biological and social issues that require special consideration in this group.

▲ Although a strong foundation of evidence already exists to inform GP-directed HIV care among MSM, further research and training programmes are needed to provide GPs with the tools to effectively serve MSM.