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An Investigation of Early Syphilis Among Men Who have Sex with Men: Alaska, 2018: Findings from a 2018 Rapid Ethnographic Assessment

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Abstract

The state of Alaska had a sharp increase in cases of primary and secondary syphilis among gay, bisexual, and other men who have sex with men (GBMSM) in 2018, centered in Anchorage. A rapid ethnographic assessment was conducted in October 2018 to examine contextual factors contributing to local increases in syphilis. The assessment team conducted qualitative interviews with 64 (N=49 interviews) key informants in Anchorage and Matanuska-Susitna Valley identified through the STD/HIV program at the Alaska Department of Health and Social Services, Division of Public Health (ADPH): ADPH staff (n = 11; 22%) Medical Providers (n = 18; 37%), Community-Based Organizations/Partners (n = 9; 18%), and GBMSM Community Members (n = 11; 22%). This project was deemed exempt from IRB review. Primary factors affecting syphilis transmission, care, and treatment among GBMSM were: (1) Low awareness about the current syphilis outbreak and ambivalence about syphilis and other STIs; (2) Aspects of sexual partnering such as travel, tourism, and the use of online sites and apps to facilitate anonymous sex and multiple (both sequential/concurrent) partnering; (3) The synergistic effects of substance use, homelessness, and transactional sex; (4) Choosing condomless sex; and (5) Challenges accessing healthcare, including the ability to find appropriate and culturally competent care. Syphilis increases may have been influenced by factors which spanned multiple sectors of the Anchorage community, including individual behavior, community-level risk and protective factors,

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and use of and interactions with resources offered by ADPH, community-based organizations, and medical providers.

Keywords

Syphilis; Gay, bisexual and other men who have sex with men; Rapid ethnographic assessment; Outbreak response; Qualitative data

Introduction

Syphilis is a bacterial sexually transmitted infection (STI) prioritized for intervention by public health departments because of its potential negative outcomes. When detected and treated in its early stages, complications usually can be avoided. Untreated syphilis, however, can lead to neurological and ophthalmological issues [1–5] and, among pregnant women, negative birth outcomes [3, 6]. Syphilis is most infectious during its primary and secondary stages (i.e., generally the six month period post infection). Increases in cases of early syphilis can be a warning sign of potential increases in HIV incidence [7–10].

Since the early 2000s, syphilis case rates in the U.S. have risen steadily [11–16]. The majority of these cases are among men who have sex with men, referred to here as gay, bisexual, or other men who have sex with men (GBMSM) [16–18]. Reinfection is common, as studies have shown that 6–22% of GBMSM diagnosed with syphilis are diagnosed again within an average of 2 years [19, 20]. The social and sexual networks of GBMSM may increase risk for syphilis infection, as well as HIV-infection, or syphilis/HIV coinfection [21]. As Spicknall et al. [22] outline, GBMSM may be more likely to fall within sexual networks with characteristics that facilitate STI spread as compared to the networks of their heterosexual counterparts. GBMSM sexual networks allow for a longer lifetime window for new sex partner acquisition compared to heterosexual men and women and are also more likely to feature closed loops (e.g. the sex partners of one individual may also be sex partners with each other) and shorter network distances (e.g. fewer partners are needed to connect men to one another within a network) [22, 23].

In 2018, the state of Alaska saw an increase in primary and secondary syphilis, primarily concentrated among GBMSM. By the first quarter of 2018, the Alaska Division of Public Health (ADPH) STD/HIV Program had already seen 23 cases, equal to each year-end total from 2015–2017. The cases were primarily in Anchorage and among GBMSM 40 years of age or older. Of the first 20 cases in 2018, one was also newly HIV infected [24, 25]. In response to a request from the state, we conducted a rapid ethnographic assessment to identify factors which could be contributing to local increases in syphilis and make recommendations for public health action to the ADPH STD/HIV Program.

Design and Methods

Using a team-based, rapid assessment approach, a four-person team of behavioral/health scientists conducted 49 in-person, semi-structured qualitative interviews with 64 key informants in Anchorage and Matanuska-Susitna Valley, Alaska (hereafter, Anchorage).

Key informants were identified through discussions with ADPH leadership, STD/HIV Program staff, key informants themselves, and local STD/HIV reporting data. We contacted medical providers who had diagnosed a case of syphilis in the previous year, all public health staff and high-priority partners providing sexual health services in Anchorage, and key informants with ties to the GBMSM community. Key informants assisted with the recruitment of members of the GBMSM community. Respondents were drawn from ADPH staff (n = 11; 22%) medical providers (n = 18; 37%), community-based organizations/ partners (n = 9; 18%), and GBMSM community members (n = 11; 22%). Verbal consent to participate and be audio-recorded was obtained prior to interviews. This project was determined to be exempt from IRB review by the Centers for Disease Control and Prevention as it was part of a larger outbreak response. Findings from a complementary epidemiological analysis can be found elsewhere [26].

We asked respondents open-ended questions about how aware they and others were of syphilis increases among GBMSM in Anchorage, what they thought was contributing to the increase, and recommendations to address the issue. Interviews were transcribed from audio files and checked for accuracy against notes and audio recordings; resulting transcripts were imported into NVivo [27]. Two team members developed an initial codebook which was refined through a series of double-coded and reconciled transcripts. All four team members were involved in subsequent coding and elicitation of themes. Detailed findings and recommendations were presented to ADPH; this report focuses solely on the possible contributing factors.

Results

Respondents were asked to share their thoughts about what was contributing to the increase in syphilis among GBMSM in Anchorage. Five themes affecting syphilis transmission, care, and treatment among GBMSM emerged: (1) Low awareness about the current syphilis outbreak and ambivalence about syphilis and other STIs; (2) Aspects of sexual partnering such as travel, tourism, and the use of online sites and apps to facilitate anonymous sex and multiple (both sequential/concurrent) partnering; (3) The synergistic effects of substance use, homelessness, and transactional sex; (4) Choosing condomless sex; and (5) Challenges accessing healthcare, including the ability to find appropriate and culturally competent care.

GBMSM Awareness

> I just don’t think that there’s a real fear of syphilis. I don’t think people understand …the potential complications. Our population is pretty desensitized to STDs. I mean, everybody and their mother’s had chlamydia and gonorrhea a bunch of times. We just have super high incidence of STDs. Having an STD up here is normal.”
>
> (APHD Staff 3)

Community members were aware of high rates of STIs in Alaska in general, but not the current syphilis increase in Anchorage, despite multiple efforts by the ADPH STD/HIV program to spread information. Many of the GBMSM community members who were aware of the increase in syphilis had been recently diagnosed or tested for syphilis, and thus had

direct contact with ADPH as the program had reached out to verify treatment and elicit partner information so exposed partners could be contacted. Several different respondent types suggested the “normalization” of having a STI coupled with the understanding that most STIs are treatable contributes to generally casual attitudes about STI risk in Alaska. Some respondents noted how consistently high rates of STIs within the state make it difficult to stress the importance of controlling the current syphilis increase and to differentiate messages regarding the current increase from ongoing prevention messaging. A few suggested that lack of knowledge about the severity of syphilis may make it a low priority for GBMSM.

Sexual Partnering: Anonymous Sex and Multiple Partners

Respondents identified several aspects of sexual partnering among GBMSM in the Anchorage area that may be related to the increase in syphilis. These factors include how travel, tourism, and the use of online sites and geospatial apps (apps) facilitate anonymous sex and multiple (both sequential and concurrent) partnering among GBMSM. Respondents acknowledged that although these factors, and sexual risk taking in general, were not unique to GBMSM, their confluence within the smaller sexual networks found in Anchorage may contribute to the syphilis increase.

Travel, Tourism, and Seasonal Workers

> “So, every time a cruise ship docks it’s another 4000–5000 people in town. And they’re only there for like 10 to 24 hours tops, so there’s a lot of hookups”
>
> (Community Member 8)

Respondents spoke of Anchorage as a transitory hub, attracting travelers, tourists, and seasonal workers from across Alaska, the lower 48 states, and other countries. Most acknowledged that limited infrastructure in other areas of the state motivates many people from outlying areas to come into Anchorage for supplies, medical care, entertainment, and employment. Many felt tourism, particularly cruise ships, gave tourists and locals opportunities to meet and have sex, sometimes in the span of hours. Some respondents suggested some GBMSM might prefer to have sexual encounters with people who are visiting Alaska or with people they encounter while traveling or vacationing because those people are outside their relatively small local social or sexual networks. Others mentioned that even within the state, movement patterns from rural to urban settings might increase in-state transmission of certain STIs. Many respondents described how common it is for residents to travel to warmer places in the lower 48 states, sometimes for the purpose of sex tourism or liaising with partners outside of Anchorage. Likewise, many respondents described a steady flow of seasonal workers moving into and out of Alaska for short-term work assignments.

Online Sites and Apps

> “I don’t think the mentality of gays has ever been different. I think the mentality is still the same, as far as the willingness to hook-up or whatever. With today’s social media and apps, it is just easier to find people. I think Grindr is the today’s version of the former chat lines, 10, 15 years ago…”

(Community Member 4)

Most respondents felt partnering behaviors among GBMSM have been relatively consistent over time and that only the avenues used for hooking-up have changed. There was general agreement among respondents that online sites and apps such as Grindr, Tinder, Scruff, etc., facilitate anonymous sex or sex with multiple partners; community members acknowledged the role of apps in making it easier and faster to "hook-up". However, there was no consensus around the extent to which respondents felt online sites and apps have increased the number or type of sexual encounters. Some felt app use may be becoming more common whereas others felt that use has remained relatively stable over time. Respondents did describe how online sites and apps may affect the amount of time an individual spends "vetting" a potential sexual partner (i.e. learning more about their sexual history) or knowing a sexual partner outside of virtual or hook-up spaces.

Substance Use, Homelessness, Transactional Sex

> "I think part of it is drug use because even though people don't always tell us, I think a lot of times there is either coercion with sex or just outright trade for places to stay that contributes to the sexually risky behavior…"

(Medical Provider 10)

Multiple respondent types discussed how substance use, homelessness, and transactional sex (i.e., trading sex for money, drugs, or a place to stay) interacted synergistically to exacerbate the potential spread of syphilis and other STIs. Although the three factors were not always described as co-occurring, most respondents mentioned at least one factor and many talked about two or more combining to make someone more vulnerable to syphilis exposure. These factors were linked to engagement in risky sexual behaviors and introduced challenges in providing care and services to affected individuals. Many respondents described the interplay of substance use, homelessness, and transactional sex as an outcome of trauma, poverty, and mental illness. A few community members talked about their substance use as a way to cope with mental health challenges brought on by trauma or economic disadvantage.

Most respondents felt substance use among GBMSM was proportionally similar to other populations in the Anchorage area and did not describe any recent changes regarding drug use behaviors among GBMSM. Respondents consistently identified alcohol, opioids, and methamphetamine as likely drivers of high-risk sexual behavior, and described substance use during sex as more likely to create disinhibition and reduce protective behaviors, putting users at higher risk for STI/HIV acquisition.

> "We have this population of [homeless] IV drug users and youth who have been all over the [foster care] system. They are self-medicating. Those folks, that is the survival mode group. They are not thinking about their safety, ever."

(Community Partner 6)

Respondents saw homelessness as a significant issue in Anchorage and the surrounding areas, and specifically for gay, lesbian, bisexual, transgender, intersex, and asexual (GLBTQIA +) youth and GBMSM. They described a range of experiences of homelessness, such as "couch surfing," living in an urban tent city, and living in the "bush" (i.e., regions

of the state not connected to the road network/ferry system). Several community partners discussed specific challenges regarding providing care and services to those at most need. For example, a community partner described how even with transportation vouchers and health insurance, many clients prioritize more immediate needs, such as food and shelter, over accessing healthcare and engaging in disease prevention. Respondents also described how many people experiencing addiction or homelessness receive crisis health care at the emergency department, where there are fewer safety net and wrap around services.

Transactional sex, though mentioned more rarely, was often described in conjunction with substance use and/or homelessness. Respondents discussed how transactional sex was sometimes used to secure a place to stay for a short time or in exchange for drugs or money. Whether because of the higher priority placed on achieving those goals or because of power imbalances inherent in these negotiations, transactional sex was discussed in association with engagement in higher-risk sexual behaviors.

Condom Use

Respondents acknowledged low condom use in Anchorage contributed to consistently high STI prevalence rates, including syphilis. The factors respondents most often linked to low condom use among GBMSM were feelings of condom fatigue, their own or their partner's desire not to use condoms, the availability of pre-exposure prophylaxis (PrEP), and awareness that an undetectable HIV viral load meant HIV was untransmittable to partners.

> "I don't think the condom message matters. I think it matters, but I do not think they hear it anymore. It is not like, 'I need to use condoms?' They have heard it, they know how to put them on, and they know when they are supposed to… They can tell you all that information, but they're just not using them."
>
> (Medical Provider 14)

Condom Fatigue and Choosing Condomless Sex

Providers overwhelmingly acknowledged that clients "have heard enough" and may be experiencing "condom fatigue", or a general weariness regarding safer sex messages. Many GBMSM community members echoed this sentiment. Some community members described how choosing not to use condoms was an expression of their own sexual agency. Others described condom use as cumbersome or failing to adapt to keep up with needs specific to anal sex. Some respondents felt that, when combined, these factors contributed to low levels of condom use across the GBMSM community.

PrEP, Viral Suppression, and U = U

> "At the end of the day, we can't get people to wear condoms. I don't think it's rocket science. We have these conversations all the time… but with PrEP and the U=U campaign and people being suppressed on antiretrovirals… the fear of HIV is definitely not what it used to be. I feel like people are just taking more risks, and it's almost like HIV has been taken off the board. …There's plenty of people who take avoiding HIV very seriously, but we talk about condoms all the time and people just kind of laugh and shrug and say, 'I know, I know, I know, I know.'"

(Medical Provider 15)

Community members and medical providers believed that PrEP and viral suppression through antiretroviral use play an important role in shaping perceptions of sexual risk among GBMSM. Some community members felt the ability to disclose one's PrEP use on dating apps had decreased stigma around HIV while also increasing the acceptability of condomless sex. Reduced fears around acquiring and transmitting HIV were described as potentially increasing the number of partners some GBMSM are willing to have. Conversely, we spoke with some respondents who did not believe PrEP has had a significant effect on behavior, especially for those individuals who were already engaging in high-risk sexual behaviors prior to PrEP's introduction. Some community members acknowledged a pitfall of feeling "safe" from the threat of HIV, and subsequently having condomless sex, increased the risk for getting other STIs. One community member who recognized that risk said he would still choose to have condomless sex because he was protected from HIV, and all other STIs were treatable once detected through regular testing.

Many respondents believed the viral suppression of HIV was another factor in GBMSM choosing condomless sex. Community members familiar with the Undetectable = Untransmittable [28], or U = U health campaign, understood that HIV + persons with an undetectable viral load were incapable of transmitting HIV to their sexual partners. For example, one medical provider talked about a client who listed himself as HIV+ with an undetectable viral load on a dating app. Although he wanted to used condoms, he experienced pressure from potential sex partners to not use condoms since he was unlikely to transmit HIV. Some respondents mentioned that although the U = U campaign helped remove the burden and stigma among HIV+ persons, it may deemphasize condom use and increase risk for acquiring other STIs. A few respondents were also concerned about how younger GBMSM who had not grown up understanding the severity of HIV on and within the GBMSM community interpret U = U. Given the effectiveness of viral suppression and PrEP, many providers felt continuing to encourage condom use among GBMSM was not especially productive.

Challenges Accessing Healthcare

"I know who I would send to the trans* doctors in town. I know where I'd send for gastric bypass in town. I know where I'd send for good mental health care. I honestly don't know who I would… You know, if a gay kid came to me, like 'I need a gay doctor', I don't know who they are."

(Community Partner 3)

Fragmented Care

Despite Anchorage being a medical hub in Alaska, some respondents were unclear about how and where to access or refer GBMSM for appropriate and culturally competent sexual healthcare. Some community respondents sought STI testing, treatment, or PrEP outside of their usual source of care. Reasons for this included recognizing they were not receiving high-quality sexual healthcare; providers not asking questions about their sexual orientation or about healthcare concerns specific to GBMSM; provider inability or unwillingness to

address certain topics (e.g., PrEP); and discomfort discussing their sexual health concerns with a provider because of perceived judgment. A number of respondents described Alaska as a conservative state and believed that conservatism extended to the provider-patient relationship, making sexual health conversations uncomfortable on both sides.

> "I feel like there should be some effort to try to empower doctors as much as possible to have these kinds of conversations with their patients… I had this initial feeling when I first met my GP [general practitioner]. You get this perception like you don't want to tell them things, and it's so critical to break down that barrier."
>
> (Community Member 9)

Respondents described the network of medical providers responsible for the sexual healthcare of GBMSM in the Anchorage area as small and interconnected, in much the same way as they described the GBMSM community itself. Many of the providers caring for GBMSM were specialty, not primary care, providers, with most operating in HIV, STI, and reproductive health settings. Many community respondents noted that they did not know where to get a syphilis test or sexual healthcare, and that it was difficult to locate a gay-friendly primary care provider. One community member mentioned that the lists of recommended GBMSM-friendly physicians available online offered only female providers, and that underlying misogyny among some in the GBMSM community translates into an unwillingness to see a female physician. Some providers found on GBMSM-friendly lists were understood to cater more to trans* individuals, rather than cis-GBMSM.

Some community partners offering services to GBMSM indicated they do not have the staffing, expertise, or resources to provide comprehensive sexual health services, or to include syphilis testing, which requires a phleboto-mist. However, several respondents noted how strategic collaborations with providers and other community-based partners helped fill service gaps and provide more comprehensive services to high priority populations.

Privacy, Distrust, and Stigma

Living in small, interconnected communities created concerns around confidentiality and privacy, especially for GBMSM who might already feel stigmatized because of their sexual identity and behavior. A few respondents felt that individuals' concerns for privacy, coupled with distrust of public (health) systems, limited the ability of the APHD STD/HIV Program to effectively communicate with infected persons and engage their partners. Some APHD respondents shared specific examples of distrust, where efforts to notify an exposed individual were dismissed because the individual did not believe that the person contacting them was actually with the APHD.

Providers: Awareness, Comfort, and Clinical Practices

Provider Awareness.

> I'd be surprised if there was 10 percent of those folks who really do know too much about this… I think, frankly, most of my colleagues are not too aware of this, because I talked to a few of them, just casually saying that I have this meeting [the interview]. They're like, 'There's an outbreak?'"

(Medical Provider 11)

We asked ADPH staff and medical providers to share their thoughts about local provider awareness of the current increase in syphilis among GBMSM in Anchorage. Most respondents believed awareness among providers varied by provider type and level of connection to ADPH. Respondents suggested infectious disease providers, providers seeing a high volume of GBMSM, Public Health Nurses, and providers who received Public Health Alerts or worked closely with the STD/HIV Program were more likely to be aware of the current increase in syphilis rates. Conversely, respondents believed that many primary care doctors were likely unaware of the increase.

> "I mean, we get bombarded with all kinds of epidemics. Part of that may be that people feel like they're constantly ordering the test, and what more can you do? I don't know how aware people are of the specific populations being affected. I had a provider that saw me last week and was like, 'I've been continually ordering these syphilis tests since day 1 for years now and I've never seen syphilis.'"

(Medical Provider 17)

Some providers talked about the need for syphilis to "make the differential", or to make the list of possible diagnoses they consider when ordering tests, which was more likely among providers aware of syphilis increases. As one provider pointed out, having syphilis on the differential list may be especially important during a syphilis outbreak to avoid missed opportunities for testing. Some providers indicated they tested for syphilis primarily on request, and many noted most providers had never seen a syphilis case. A few medical providers suggested that because it is rare to diagnose or treat a syphilis case, the perceived importance of continued screening in the face of no positive results is decreased. Some noted the combination of (historically) not seeing syphilis cases and not being aware of current increases in syphilis cases may create missed opportunities not only for appropriate testing for syphilis but also for taking detailed sexual histories and conducting routine and extragenital screening/testing to identify chlamydia or gonorrhea among high-risk patients.

Provider Comfort and Clinical Practice

> "A lot of my PrEP patients will tell me they had to search to find PrEP, and that their primary care provider has never asked them their sexual preferences, their sexual orientation. [They're] not getting rectal or pharyngeal screening for gonorrhea and chlamydia, and then a lot of people [have] never even had one HIV screen."

(Medical Provider 10)

Most providers agreed that ordering a syphilis test was relatively easy, and for many, much easier than talking to someone about their syphilis risk. Patients who had symptoms or a sex partner who tested positive for syphilis were described as most likely to seek testing. Outside of this, GBMSM who tested regularly for syphilis were often men on PrEP or in HIV care.

> "I think what people are uncomfortable with is screening gay men who are having sex with other men, who are having anal sex and finding relationships online. The biggest thing I am asked to do over at the family medicine residency is

> simply role-play taking a sex history for somebody that is not in a heterosexual monogamous relationship. So, I think that is what providers are uncomfortable with. They're uncomfortable asking people about their sexual orientation, and even further, they're uncomfortable about asking people about what sex acts they're doing or if they might have multiple partners or how they're accessing those partners…Across the board, I see health care providers all the time having like zero competency with taking a sex history from a queer person."
>
> (Medical Provider 5)

In primary care settings, identifying at-risk GBMSM often depended upon a provider having an up-to-date sexual history. Providers who took more comprehensive and GBMSM-friendly sexual histories emphasized the importance of including questions on gender identity and preferred pronouns, gender identity of partners, number of partners (including those outside of a primary relationship), condom use, history of STIs and HIV, their partner's HIV status, and what sexual acts they engaged in (including whether they were a top, bottom, or versatile). Few providers mentioned taking a sexual history of this depth and breadth who were not also seeing a high volume of GBMSM. Respondents talked about how an environment that fostered open communication about sexual health started well before the visit, including on intake forms. As one provider noted, if people do not see questions or options on intake forms that reflect who they are, it creates a comfort and communication barrier.

Discussion

Findings highlight factors affecting syphilis transmission, care, and treatment among GBMSM that involve multiple sectors of the Anchorage community: (1) Low awareness about the current syphilis outbreak and ambivalence about syphilis and other STIs; (2) Aspects of sexual partnering such as travel, tourism, and the use of online sites and apps to facilitate anonymous sex and multiple (both sequential/concurrent) partnering; (3) The synergistic effects of substance use, homelessness, and transactional sex; (4) Choosing condomless sex; and (5) Challenges accessing healthcare, including the ability to find appropriate and culturally competent care.

These findings reflect and add to other observations examining the spread of syphilis among GBMSM. At the time of the assessment, many GBMSM in Anchorage were unaware of the syphilis increases despite the efforts of the STD/HIV Program. Although awareness is a critical part of reaching men who may be at risk for syphilis, awareness alone is unlikely to stem rising rates. STI prevention is not a primary concern for many GBMSM, in Alaska or elsewhere, who have heard prevention messages and understand the importance of prevention measures like condom use but who recognize that many STIs can be detected through routine screening and easily cured. Advances in HIV prevention such as viral suppression and PrEP, combined with less concern about STIs, may decrease interest in prevention efforts outside of routine testing. For example, in qualitative interviews with MSM with repeated syphilis infections in Los Angeles County, most participants believed syphilis was a "dangerous" disease with serious sequelae. Despite this, most men indicated

they were unlikely to change their sexual behaviors as a result of multiple syphilis infections [29].

Likewise, as elsewhere, GBMSM in Anchorage used websites and apps to find partners. Some research suggests that the use of the internet to find partners is reported frequently by GBMSM diagnosed with syphilis [30, 31], and GBMSM who find sex partners online are more likely to have unprotected anal intercourse [32]. Although methods for finding sex partners have always existed and continue to adapt alongside technological advancements, websites and apps may allow for a more diverse mix of potential sex partners than methods more constrained by geography (e.g., bars). Syphilis can be thought of, at least in part, as a disease of networks, and its entry into a pre-existing, relatively contained network can facilitate spread. In isolation, the small sexual networks among GBMSM in Anchorage would be relatively dense and closed. However, travel and tourism both within Alaska and to the lower 48 states, along with influxes of seasonal laborers, may bridge local and distal sexual networks [33, 34]. When combined with rising syphilis rates nation- and world-wide, persistent condom fatigue, viral suppression and PrEP to prevent HIV transmission and acquisition, and the belief among many GBMSM that most STIs are easily cured and so not a concern, it is not surprising that syphilis rates have increased among GBMSM in Anchorage.

Previous research indicates the difficulty of prompting behavior change among high-risk GBMSM [35, 36], With the re-emergence of syphilis as a growing public health concern, researchers have suggested a number of possible interventions, with an emphasis on screening and treatment [37]. Modeling work indicates that enhanced syphilis screening among men with a known prior case of syphilis may be an effective way of curbing the spread of syphilis in the community [38]. However challenges persist, as data from some locations indicates that the utility of partner services to find partners of incident syphilis cases has been declining precipitously [39]. Although partner/contact tracing is a fundamental public health intervention, additional resources and partnerships could be leveraged to widen the scope and effectiveness of STI prevention methods.

Healthcare provision similarly offers areas for improvement, as there are challenges to GBMSM accessing healthcare, including sexual health services. Providers most aware of syphilis increases and most confident in addressing syphilis were specialty rather than primary care providers. For some GBMSM, this required additional resourcefulness and steps in their healthcare seeking process to find a provider who was attuned to the needs of GBMSM and up-to-date on local epidemiology. As found elsewhere [40], providers and community members indicated that experience taking and having up-to-date, culturally-appropriate sexual histories facilitated STI screening among high-risk patients, providing comprehensive sexual health care to GBMSM, and identifying other needed services, like three-site extragenital screening for chlamydia and gonorrhea. The latter may be especially important for GBMSM to detect chlamydia and gonorrhea infections which would not be identified through traditional urine-based testing. However, given the challenges some providers have discussing sexual health, collecting extensive sexual history information, and conducting syphilis testing as a routine part of healthcare, it may be prudent to direct at-risk individuals to providers in the community who have been identified as providing

high-quality sexual healthcare to GBMSM. Additionally, providing training and guidance on conducting inclusive sexual health histories to primary care providers may help increase the access and quality of sexual health services, including appropriate screenings, for GBMSM.

Limitations

The data presented are based on a small, purposive sample of key informants we interviewed in the Anchorage area. The findings represent the experiences and perspectives of the respondents and should not be generalized to the Anchorage-area population as a whole. REAs use qualitative methods including interview techniques to provide a rich understanding of local factors which may help explain health-related phenomena. They are not designed to measure the extent of the issue [41, 42].

Conclusions

Rapid ethnographic assessment is a public health tool used since the 1970s to systematically collect time-sensitive data using qualitative methods [41, 42]. It complements public health efforts by providing rich, contextual data from an insider's perspective to explore issues or questions that arise during surveillance, program, and research activities [41]. This assessment also identified resources and partnerships in Anchorage to support syphilis prevention efforts in addition to those already put into action by the ADPH STD/HIV Program. It may also help public health agencies identify possible interventions which best fit their local context and take advantage of the resources available to public health, providers, community-partners, and among the GBMSM community itself.

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