CD Summary

June 17, 2003
Vol. 52, No. 12

Telephone 503/731-4024
Emergencies 503/731-4030
Fax 503/731-4798
cd.summary@state.or.us
www.dhs.state.or.us/publichealth/cdsummary/

AN EPIDEMIOLOGY PUBLICATION OF THE OREGON DEPARTMENT OF HUMAN SERVICES

HIV AMONG MEN WHO HAVE SEX WITH MEN: A SNAPSHOT OF OREGON

HIV AND AIDS have been with us for over two decades. Despite the established contributions of community-based prevention campaigns aimed at keeping HIV-seronegative individuals free from infection, these programs have fallen short of complete success. With the estimated number of new HIV infections in the United States hovering at 40,000 annually, the damage of HIV disease has touched every corner of society. HIV risk behaviors are increasing among men who have sex with men (MSM) in a number of locations nationally.[1] The HIV epidemic and the evolving complexities of HIV disease itself compel us to find new and innovative prevention approaches.

In 2002, Program Design and Evaluation Services (PDES)—an evaluation unit jointly administered by Oregon Department of Human Services (DHS) and Multnomah County Health Department—conducted a study to update our understanding of the health and HIV prevention needs of Oregon's MSM. This "Snapshot of Oregon" included focus groups and a statewide survey of both HIV-negative and HIV-positive MSM and asked about HIV-related attitudes and perceptions held by MSM, as well as behavioral risk factors. The Snapshot surveys, anonymous and self-administered, were distributed through community outreach, events, snowball sampling via peer referral and other means. Between June and October 2002, 748 surveys were received by MSM from 20 different counties in Oregon. Four focus groups (33 participants total) were conducted in November 2002 in Portland and Grants Pass. MSM with HIV-positive or HIV-negative or unknown serostatus were recruited via advertisements in gay or HIV-related venues. A selection of the study findings are highlighted below.

RESULTS

Influence of New HIV Treatments

Most MSM surveyed agreed that because of new treatments they are less worried than they used to be about AIDS and HIV. Focus groups felt that there is a perception that HIV has become treatable, similar to other chronic health conditions or sexually transmitted diseases.

Incorrect assumptions about HIV were held by a high number of MSM. For instance, 13% of the MSM agreed with the statement: "It is safe to have sex without a condom if the HIV-positive person has an undetectable viral load" [n=688]. Latino MSM, HIV-positive MSM and MSM from counties with a higher HIV incidence were more likely to agree with this statement.

Condom Use and Unprotected Anal Intercourse (UAI)

About half of MSM surveyed said they had used a condom the last time they had anal sex, and about half said they'd had unprotected anal intercourse (see Figure). HIV-positive respondents were as likely as HIV-negative MSM to have practiced anal intercourse without protection at their last sexual encounter. Our findings showed inconsistent condom use over the last two months (see Figure). Additionally, MSM who reported a substance use issue were more likely to report inconsistent condom use during anal sex over the past two months.

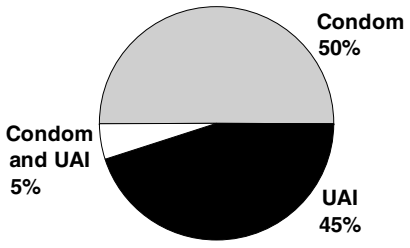
Reasons for Not Using Condoms

In both the survey and in focus groups, MSM cited several reasons for not using condoms. Among HIV-positive respondents the most common reasons included: both my partner and I are HIV positive; I don't like wearing a condom; my partner doesn't like wearing a condom; I'm HIV-positive already.

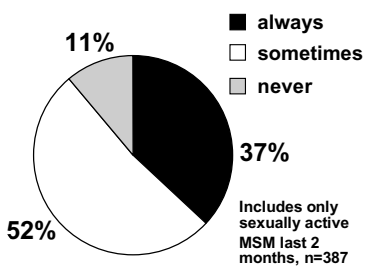
HIV PREVENTION MESSAGES

Less than 45% of the MSM surveyed had seen or heard HIV messages in the past year from a public or private healthcare provider. MSM in more rural parts of Oregon

MSM condom use at last encounter (n=652)



MSM condom use, last 2 months (n=387)



The **CD Summary** (ISSN 0744-7035) is published biweekly, free of charge, by the Oregon Dept. of Human Services, Office of Communicable Disease and Epidemiology, 800 NE Oregon St., Portland, OR 97232
Periodicals postage paid at Portland, Oregon.
Postmaster—send address changes to:
CD Summary, 800 NE Oregon St., Suite 730, Portland, OR 97232

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were more likely to hear or see HIV messages at public health departments than those in Oregon's five most populated counties. Focus group participants felt that prevention messages might be more effective if HIV were addressed together with other health concerns such as STD and hepatitis prevention. HIV-positive focus group participants felt that there should be more visible information for the HIV-positive audience, specifically regarding HIV re-infection, different HIV strains, HIV epidemiology and treatment information.

RECOMMENDATIONS

Although several implications can be generated from these data, one of our major recommendations is that more HIV prevention education and more specific messages can be delivered to MSM, both HIV-negative and HIV-positive, in public and private healthcare settings. Messages that encourage consistent condom use and emphasize correct knowledge about the effect of HIV treatments may be valuable. Hecht (2001) and Schreibman and Griedland (2003) provide some ideas about integrating HIV prevention into the clinical setting.[2,3]

Patients trust their doctors

Research indicates that patients view clinicians as a trusted source for prevention information and want to discuss issues like sex and HIV prevention.[3] The creation of a nonjudgmental atmosphere in which the patient and clinician can openly discuss these issues is important. Avoiding one-way educational approaches in favor of more interactive counseling encourages patients to describe their behaviors and craft their own solutions.

Consistently deliver prevention messages

Recognizing the unique needs of each patient is necessary for successful prevention plans. While prevention discussions may be part of initial encounters, a patient's lifestyle, choice of partners, and behaviors may change over time. Consistently delivering prevention messages and finding opportunities to assess a patient's prevention needs will serve both clinician and patient well.

Create scripted phrases

Scripted phrases can help introduce prevention conversations and deliver them in more sensitive ways. Since patients are the most knowledgeable about their own behavior, it is recommended that clinicians practice some general questions that broach the subject of HIV risk behavior and that encourage patients to lead the discussions.[2,3] Some of these questions might be:

"Now that we've finished discussing your medications, I'd like to ask you some questions about your drug and sex behaviors. What behaviors are you involved in now? Would you feel comfortable discussing them?"

"How might you be able to reduce the riskiness of your sex and drug use behaviors? What do you see as your next steps?"

"How important is reducing your risk behavior to you (on a scale of 1 to 10), and how confident are you that you can do this (on a scale of 1 to 10)?"

By integrating HIV prevention strategies into routine clinical care services, public health and private medical care systems can help curb new HIV infections in Oregon, particularly with HIV positive patients. The challenge, of course, is overcoming barriers in doing so.

For the complete report of *A Snapshot of Oregon: Understanding The HIV Risk of Men who Have Sex with Men*, please contact DHS: HIV/STD/TB Program at 503/731-4029 after July 2003.

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Apologies for the lateness of this issue. We have lately been experiencing some technical and editorial challenges. Your patience is appreciated.