

## ARE WE LOSING GROUND IN HIV PREVENTION?

JUNE 6, 2001 MARKS the 20th anniversary of the first report alerting the world to the AIDS epidemic.<sup>1</sup> We have learned much about the epidemic and how to combat it since that time. Knowledge of how HIV is transmitted led to screening of blood products for HIV and changes in sexual behaviors among high-risk groups, and treatment advances have prolonged life and decreased infectivity for those already infected.

Men who contracted HIV from sexual activity with other men still account for the largest risk group among HIV-infected persons, and now there are signs that there may be an increase in high-risk sexual behavior among men who have sex with men (MSM). Reports of increasing rectal gonorrhea in MSM<sup>2,3</sup> and increases in self-reported unprotected anal intercourse in MSM from several cities around the US are worrisome predictors of increased risk for HIV. Ironically, these increases in risk behaviors coincide with the availability of effective antiviral therapy. Many are concerned that the availability of therapy might lead to increased risk behavior by MSM who perceive that HIV infection can be managed effectively.<sup>4</sup> This issue of the *CD Summary* reviews the data on gonorrhea and syphilis among Oregon MSM as indicators of changes in sexual behavior that may put MSM at increased risk of contracting HIV. In addition, we review self-reported data on sexual behavior among MSM, and discuss how HIV prevention activities are seeking to address these changes.

### GONORRHEA

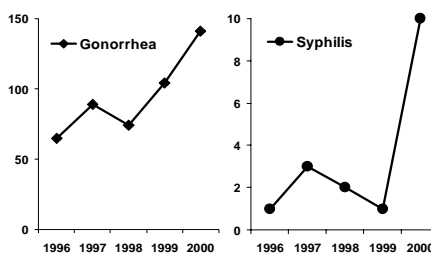
The number of persons reported with gonorrhea (GC) has increased from an all-time low of 773 cases in 1997 to 1039 in 2000. Of the year 2000 cases, 141 were in MSM. This compares to 89 cases in 1997 and represents a 36% increase. Almost all (137/141, 97%) of the MSM who contracted GC in 2000 reside in Multnomah County, and the vast majority of these men are white. In addition, the increase in

Multnomah County MSM cases has occurred in all age groups, but particularly in those above age 19.

### SYPHILIS

Syphilis is a much rarer disease in Oregon than GC. Although the numbers are small, recent syphilis case reports also suggest a worrisome trend in risky sexual behavior among MSM. In 1998 there were 13 cases of early syphilis with only 2 (15%) of the males being MSM. In 2000 there were 32 early cases with 10 (31%) of the males being MSM. With the exception of one case, all of these MSM were residents of Portland.

Gonorrhea and syphilis cases in MSM by age group, Oregon 1995-2000



### SELF-REPORTED DATA ON SEXUAL BEHAVIOR

Self-reported data are also available on attitudes towards infection risk and on sexual practices. These data come from the HIV Testing Survey, a cross-sectional survey administered to Oregonians at high risk for HIV infection recruited from STD clinics, drug-treatment programs and bars that cater to gay men. Surveys were performed in 1996 (n=296) and 1998 (n=318). Overall in 1998, fewer men reported that getting an HIV test was stressful to them (OR=2.0; 95% CI: 1.4, 2.8). Over two-thirds of respondents in both years reported engaging in unprotected anal intercourse, and over two-thirds also reported that their perceived risk of contracting HIV is low. These data suggest that an increasing number of MSM may be underestimating their personal risk for HIV infection while continuing to practice risky behaviors.

Self-reported data on high-risk sexual practices are also available from HIV Counseling and Testing Sites at Oregon's health departments. Persons who test at health departments are asked several questions about their sexual risk behavior in the last six months. Data are missing on a substantial portion (38%) of MSM testing, but of the 3,486 MSM who responded to these questions in 2000, the percentage of men engaging in unprotected insertive or receptive anal intercourse was 45%, and the percentage reporting unprotected oral intercourse was 93%. The results indicate a high level of unprotected sex in MSM.

### SO HOW DOES ALL THIS ADD UP?

While the trends in GC and syphilis among MSM are worrisome, many factors may be driving those increases. Among other factors, for example, it's possible that simply an influx of MSM into Oregon might result in an increased number of cases, even if there was no increase in the likelihood that individuals were engaging in high-risk sexual behavior. Nevertheless, when the increase in GC and syphilis cases is taken together with the self-reported data, it's hard not to conclude that changing attitudes and sexual behaviors among Oregon MSM are worrisome.

### ARE OREGON MSM UNIQUE?

We all believe that Oregon is special, but unfortunately these trends are not unique to Oregon MSM. Several other major west coast cities have also reported increased syphilis and GC, as well as high rates of unsafe sexual behavior in MSM.

In Seattle, the proportion of syphilis cases in MSM increased from 21% (four of 19) in 1997 to 85% (75 of 88) in 1998 and 1999. These men reported 740 sex partners, 88% of whom were met at anonymous venues such as bath houses, bars, or clubs, and 79% had had at least one anonymous partner. In addition, cases of rectal GC infection increased from six cases in 1997 to 25 cases in 1998 and 13 cases during January–June 1999. The fact that 72% of the 1998–9 syphilis cases and 19% of the



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1999 rectal GC cases were HIV-positive underscores how common risk behaviors underlie transmission of all of these illnesses.<sup>5</sup>

Increases in unsafe sexual behavior in MSM have also been documented in San Francisco. In one survey the proportion of MSM reporting “always” using condoms when they had anal sex declined from 69.6% to 60.8% ( $p < 0.01$ ). The proportion of men who reported having had multiple sex partners and unprotected anal intercourse increased from 23.6% to 33.3%. These changes occurred in all racial/ethnic groups. Over two-thirds of those persons having unprotected anal sex did not know the HIV serostatus of their partners.

In Southern California, a large syphilis outbreak also occurred in MSM during January–July 2000. Of the 57 who knew their HIV serostatus, 34 (60%) reported that they were HIV-positive.

#### **THE CONTINUED CHALLENGE FOR HIV PREVENTION PROGRAMS**

So unfortunately, our HIV Prevention Program is not about to be put out of business. Prevention activities targeted toward MSM across all racial/ethnic and age groups will continue to be a high priority, and as the descriptive data on GC and syphilis above suggest, MSM residing in Multnomah County need to be an important focus for prevention efforts. In addition, with the implementation of new reporting rules now scheduled for October 1, 2001, improved data on incident HIV infections should be available to help guide prevention activities, so we will not need to rely so heavily on indirect indicators of HIV infection risk such as rates of other sexually transmitted diseases.

Oregon’s HIV Prevention Program has a Statewide HIV Prevention Plan that has been designed with extensive input from community partners and the HIV Prevention Planning Group. Prioritized interventions for MSM in the 2001-2002 Prevention Plan include the following:

- outreach to hard-to-reach men with risk reduction education;
- educational and counseling groups to help men determine what underlies the continuation of high-risk behaviors and to help them overcome barriers to safer sex activities;
- media campaigns to help men personalize their risks and change their behavior;
- case management for those already infected to help prevent them from infecting others, and
- improved partner notification and counseling for those diagnosed with a sexually transmitted disease and/or HIV.

Of course, MSM are not the only risk group for which prevention activities must be focused. National data indicate that rates of HIV infection are increasing most rapidly among several other groups, including intravenous drug users, women and persons of color. Although not discussed in this article, prevention activities focused on these growing risk groups are also important priorities for Oregon’s program.

While many of these prevention activities will occur in the public health setting, clinicians have an important role to play as well. Patients with diagnoses indicating sexual activity that puts them at risk for HIV infection should be counseled. In

addition, it is particularly important that HIV-positive patients are counseled appropriately, since they have the potential to be the source of new HIV infections in their partners.

Clinicians can also assist the public health system by facilitating partner notification. Disease Intervention Specialists who are trained in tracing sexual contacts of patients with other sexually transmitted diseases are available through local health departments. Partners are told that they have been exposed but are not told the name of the person who exposed them, so the patient’s confidentiality is protected. Disease Intervention Specialists will provide this service for HIV-positive patients that request it. For more information about partner notification services in your area contact your local health department, or the Health Division’s HST Program at 503/731-4029.

#### **REFERENCES**

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#### **Clarification**

It was brought to our attention that access to the colon is not as restricted as we previously stated in issue #9 on colorectal cancer screening. Many other physicians, in addition to gastroenterologists, have received training to perform colonoscopies.