HIV and MSM

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Learning Objectives

At the conclusion of this presentation, participants should be able to:

• Identify HIV risk factors, health perceptions, and access to care issues among MSM individuals in your practice which differ from non-MSM patients.

• Employ new prevention, evaluation, and treatment strategies to ensure culturally competent delivery of HIV-related health services to MSM populations.
Off-Label Disclosure

This presentation will not discuss any non-FDA approved or investigational uses of any products or devices.
HIV & MSM – Statistics

• MSM account for only 4% of the U.S. population and...
  • 48% of the more than one million people living with HIV/AIDS in the U.S. (532,000 total persons)
  • 53% of all new HIV infections in the U.S. each year (28,700 infections)
  • have an incidence rate that is 44 times that of other men in the U.S. (522-989 per 100,000 vs. 12 per 100,000 in other men)
  • are the only risk group in the U.S. in which new HIV infections are increasing
Estimates of New HIV Infections, 2006, by Race/Ethnicity, Risk Group, and Gender for the Most Affected U.S. Subpopulations*

Gay and bisexual men of all races and black heterosexuals account for the greatest number of new HIV infections in the United States.

*Subpopulations representing 2 percent or less of the overall U.S. epidemic are not reflected in this chart.
The primary ages at which MSM become infected differ by race:

<table>
<thead>
<tr>
<th>Race</th>
<th>Total</th>
<th>13-29</th>
<th>30-39</th>
<th>40-49</th>
<th>50+</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>13230</td>
<td>3330</td>
<td>4670</td>
<td>3740</td>
<td>1490</td>
</tr>
<tr>
<td></td>
<td>(46%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>10130</td>
<td>5220</td>
<td>2500</td>
<td>1800</td>
<td>610</td>
</tr>
<tr>
<td></td>
<td>(35%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>5360</td>
<td>2300</td>
<td>1870</td>
<td>950</td>
<td>240</td>
</tr>
<tr>
<td></td>
<td>(19%)</td>
<td></td>
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</tr>
</tbody>
</table>
HIV & MSM – Statistics

Estimated Number* of New HIV Infections in Men Who Have Sex with Men, by Race/Ethnicity and Age Group, United States, 2006

* Incidence estimates are adjusted for reporting delays and reclassification of cases reported without a known risk factor for human immunodeficiency virus (HIV) but not for underreporting

† Non-Hispanic whites and non-Hispanic blacks are referred to as white and black, respectively. Persons of Hispanic ethnicity might be of any race

Note: The “I” bars denote the data range for each confidence interval
HIV & MSM – Risk Factors

- High Prevalence of HIV\(^1\)
- Substance Abuse\(^1,3\)
- Number of Sex Partners\(^3\)
- Unprotected Receptive Anal Intercourse\(^3\)
- Depression Symptoms\(^3\)
HIV & MSM – Health Perceptions

- Lack of Knowledge of HIV Status\(^1\)
- Complacency about HIV Risk\(^1\)
- Social Discrimination\(^1\): Homophobia, Minority Stress\(^4\)
- Cultural Issues: Stigma\(^1\)
HIV & MSM – Access to Care

- 25% of people living with HIV/AIDS in the US are undiagnosed and unaware of their HIV status\(^5\)
- Homophobia in medical practice is a reality
  - U.S. Nursing Student Study 1998: 40-43% thought LGB people should keep their sexuality private; 8-12% “despised” LGB people; 5-12% found LGB people “disgusting”\(^6\)
  - Homosexuality was listed as a medical disorder in the *Diagnostic and Statistical Manual of Mental Disorders* until 1973\(^4\)
HIV & MSM – Access to Care

• Due to fear of negative consequences, MSM are particularly unlikely to reveal information about their sexual orientation spontaneously\(^4\)

• HIV/AIDS-related stigma affects issues related to HIV testing including delays in testing, the effect of delay on further transmission of HIV, and individuals’ responses to testing positive\(^7\)

• Only 11-37% of primary care clinicians obtain a sexual history routinely in encounters with new patients\(^4\)
Improving Care – Prevention\textsuperscript{8}

CDC Recommendations [Evidence Level C, expert opinion]:

1. MSM, including those with HIV infection, should routinely undergo nonjudgmental STD/HIV risk assessment and client-centered prevention counseling to reduce the likelihood of acquiring or transmitting HIV or other STD’s.

2. Clinicians should be familiar with local community resources available to assist MSM at high risk in facilitating behavioral change.

3. Vaccination against hepatitis A & B is recommended for all MSM in whom previous infection or immunization cannot be documented (consider preimmunization serologic testing).
Improving Care – Evaluation

CDC Recommendations [Evidence Level C, expert opinion]:

1. Clinicians should assess the risk of STD’s for all male patients, including a routine inquiry about the sex of patients’ sex partners

2. Clinicians should routinely ask sexually active MSM about symptoms consistent with common STD’s, including urethral discharge, dysuria, genital/perianal ulcers, regional lymphadenopathy, skin rash, and anorectal symptoms consistent with proctitis

3. Clinicians should maintain a low threshold for diagnostic testing of symptomatic patients
Improving Care – Evaluation

CDC Recommendations [Evidence Level C, expert opinion):

4. These tests should be performed at least annually for sexually active MSM

- HIV serology, if HIV negative or not tested within the previous year
- Syphilis serology (RPR with titer and FTA if RPR is positive)
- Urethral *N. gonorrhoeae* and *C. trachomatis* testing
- Rectal *N. gonorrhoeae* and *C. trachomatis* testing
- Pharyngeal *N. gonorrhoeae* testing
Improving Care – Evaluation

CDC Recommendations [Evidence Level C, expert opinion):

5. Increase STD/HIV screening interval to q3-6 months for MSM who…

- Have multiple or anonymous partners
- Have sex in conjunction with illicit drug use
- Use methamphetamine
- Have sex partners who participate in any of the above behaviors
Improving Care – Treatment

• Create a Welcoming Environment
  - LGBT friendly symbols, posters, brochures
  - **Visible** nondiscrimination/mission statement
  - Participation in provider referral programs

• Attain/Develop Cultural Competency
  - Inclusive/sensitive language on forms
  - **Prepare** ➔ trainings, role play
  - Be aware of additional barriers
Improving Care – Treatment

- Set the mood…
  - Include sexual history as part of an overall social history (employment, living situation, tobacco, alcohol, drugs, travel history, safety eval, etc.)
  - Mention that sexual history-taking is routine in your practice
  - Reassure patient re: confidentiality
Improving Care – Treatment

• Asking Questions…
  ❑ Focus on sexual behavior, not identity
  ❑ Accept patients’ desire to withhold information, but offer to revisit the question at a later date
  ❑ Avoid labels (straight, gay, DL, bisexual, etc.)
  ❑ Ask questions in a direct, non-judgmental, and normalizing (“some people do XYZ; have you ever done this?”) way
  ❑ Frame follow-up questions (“I’m going to ask you more questions about XYZ because…”)
Improving Care – Treatment

• Answering Questions…
  - Thank the patient for asking a question or revealing information about his sexual history
  - Explore patient’s level of self-acceptance
  - Active listening → repeat back to patient
  - Don’t forget to screen for abuse and then act on it
  - Have condoms and penis models available
  - Set self-management goals based on patient’s stage of change; revisit these at every visit
References


