

PRIORITY 2: Males who have Unsafe Sex with Males (MSM)

BEHAVIORAL POPULATION DESCRIPTION

Males who have unsafe¹ sex with other males (MSM) are not a single homogenous group. MSM represent a wide variety of men of different ages, races, socioeconomic backgrounds and gender identities. They have diverse health and social needs. They are at risk for acquiring or transmitting HIV because of the unprotected sexual behaviors they engage in, not because of how they identify themselves. Anecdotal information indicates that Gay-identified males make up the majority of infections in Maine and should be the main focus of prevention activities for MSM.

For males who have unsafe sex with HIV+ males or males of unknown HIV status, unprotected receptive anal intercourse remains the greatest risk for HIV infection. A latex condom is the most commonly recognized protective device when engaging in anal sex. Unprotected anal intercourse is engaging in anal intercourse without using a condom. HIV is transmitted from an HIV positive man to an HIV negative man through HIV-infected bodily fluids, including blood, semen, and pre-ejaculate fluid.

The HIV epidemic has become strongly associated with gay men in the U.S. Both the reality and the myths of HIV are woven into the physical, psychological, emotional, and social aspects of gay men's lives including dating and intimacy, sexual desire and love, abuse and coercion, alcohol and recreational drug use. Many forms of discrimination, such as racism, socio-economic class, heterosexism, homophobia, transphobia, affect the individual self-esteem of gay men and impacts the spread of HIV among MSM. It is important that HIV prevention activities acknowledge these factors and address them when possible.

Risk Profile for MSM

There are several factors, usually acting in combination, that influence the level of risk for HIV infection among MSM. These HIV prevention factors include behavior, HIV status, individual attitudes, beliefs and feelings, individual mental and emotional health status, addictions, social and cultural norms both from within the MSM population and from the society as a whole, and a variety of institutions and systems. Some of these factors exist within each person, such as behavior, HIV status, attitudes, feelings and beliefs, individual mental health status, and addictions, and are affected by outside forces. Other factors exist outside of the person, such as social and cultural norms, institutions and systems, but affect individual decisions about HIV prevention. Each of these HIV prevention factors are important to the work of HIV prevention and are described in what follows.

¹ The word "unsafe" is defined in this report as any sexual episode in which there is no or very little protection put in place to prevent HIV infection. Unsafe means unprotected.

Behaviors

Certain behaviors, called HIV risk behaviors, increase the level of risk for infection among MSM. The following is a list of HIV risk behaviors for MSM. While they are not listed in order of priority, having unprotected receptive anal intercourse is the highest risk behavior for HIV infection.

- Having unprotected receptive anal intercourse
- Having unprotected insertive anal intercourse
- Having unprotected sex with multiple partners
- Having multiple unprotected sexual encounters
- Using alcohol and other drugs in combination with unprotected sex
- Exchanging sex for money (as in sex work or prostitution), and/or goods and/or services (e.g. lodging, food, clothing etc.)
- Having a sexual addiction or compulsive need to have sex
- Sharing needles and injection equipment to inject substances, including illegal drugs, hormones and steroids

HIV risk behaviors have the most direct relationship to HIV prevention. Over 25 years of research has identified that HIV is a preventable disease. Research has identified the specific behaviors that result in 100% prevention, other behaviors that result in higher, but not complete, levels of prevention, behaviors that offer a low level of prevention, and those behaviors that offer no preventative benefit.

The other risk factors described in the following sections have a more indirect relationship to HIV prevention. They influence the decisions to engage in behaviors. As such these factors can either support or undermine preventive behaviors from occurring on a case-by-case basis.

HIV Status (HIV negative, positive, unknown)

In combination with HIV risk behaviors, the HIV status of partners is a key factor that influences HIV infection. HIV infection is the result of HIV passing from a person (positive) infected with HIV to a person (negative) uninfected with HIV. Semen and blood are the most common vehicles that transport HIV. For MSM, unprotected receptive anal intercourse is the most common risk behavior that causes infection.

To reduce their risk of infection, some MSM focus on the HIV status of partners rather than the risk behavior. Through a practice known as sero-sorting, the theory goes that if partners who know their status have the same HIV status (negative or positive), there is no risk of HIV infection or negative health consequences. Theoretically, if two negative men engage in unprotected anal intercourse there is no risk of infection because HIV is not present. Similarly, if two positive men engage in unprotected anal intercourse, no new infection will result and there will be no negative health consequences for the individuals because they both are already infected with HIV. However, while the theory seems to make common sense, research has shown that there is risk in sero-sorting. New

infections do result among negative sero-sorters and there are serious negative health consequences for positive sero-sorters.

For positive men, we know that new and different strains of HIV can be passed to each other, including drug-resistant strains that can adversely affect health. For negative men, the accuracy of the negative result is called into question. Accuracy of a negative result depends on two primary factors that both must be present: (1) The negative result must be reported truthfully and (2) both partners must understand for a negative result to be accurate, all three of the following conditions must be met:

- The test giving a negative result must have been performed at least 3 months after the last episode of engaging in a risk behavior for HIV.
- At least 3 months have passed since the person with the negative result was tested.
- The person with the negative result has not engaged in a risk behavior for HIV since he received the test

Because the criteria for accuracy of negative results are so exacting and understanding of these requirements are not well understood or discussed, negative MSM who are sero-sorting may not be doing so correctly.

The group of people who are untested for HIV and therefore, whose HIV status is unknown represent a challenge for HIV prevention. There are three important facts related to unknown HIV status.

1. The U.S. Centers for Disease Control and Prevention (CDC) estimate that about 25% of people infected with HIV don't know it because they haven't been tested. In Maine, that proportion represents about 300-500 people.
2. The U.S. CDC estimate that more than half of HIV infected adolescents don't know it because they haven't been tested.
3. The U.S. CDC estimate that more than half, from 50% to 70%, of new infections are caused by people who are infected but untested and unaware of their infection.

In summary, the relationship between HIV prevention and HIV risk behaviors and HIV status is critical but complex. Many of the risk factors that follow are factors that influence behavior as well as a person's decision to be HIV tested and to clearly understand what test results mean.

Individual attitudes, beliefs and feelings concerning HIV and risk

How a person feels, the things they believe in, and the attitudes they hold are other important factors that influence HIV prevention. Individual attitudes, beliefs and feelings must support positive HIV prevention actions, in order to up the chances for the actions to occur. By support, Men must believe that HIV is a serious enough threat to them to do something about.

Men must believe their bodies and health are worth protecting
Men must believe that the information they are given by science, the government, and community providers is true.
Men must believe they can carry out the behaviors they need to prevent HIV infection.

Some of the feelings and beliefs that have been identified by recent needs assessment of MSM in Maine are not supportive of HIV prevention

- The feeling that unprotected sex is better and the belief that condoms decrease sexual pleasure.
- The belief that HIV is not a big deal anymore

Individual mental and emotional status

A person's mental and emotional health status is another important factor affecting HIV prevention. Such conditions as a diagnosed mental illness, depression (often undiagnosed), level of self-esteem, loneliness, and a history of trauma and/or abuse are factors, which can either support or undermine HIV prevention behaviors.

Addictions

There are three primary addictive states that can seriously undermine HIV prevention actions and behaviors. Untreated, these addictions exert strong control over a person's behavior in unpredictable ways. They are:

- Drugs
- Alcohol (the substance of choice in Maine for MSM)
- Sex

Social and Cultural Norms

Social and cultural norms are the generally accepted rules and beliefs of society as a whole or groups of people who share some common characteristics. For MSM, gay male cultural norms can have a strong influence on individual behaviors. Examples of gay cultural norms that adversely affect HIV prevention include the belief HIV is no longer a big problem because of available treatments and the belief that HIV is a gay man's destiny. Norms of society or of other dominant cultural groups also influence HIV prevention among MSM. Societal norms of homophobia and oppression of gay people are examples.

Systems and Institutions

Systems and institutions are broadly organized and established entities that function for some specific purpose. Examples include the education system, the criminal justice system, religious institutions, governmental services, mental health systems, and substance abuse treatment systems. These systems and institutions have norms and values that are specific to the individual system or institution. Some systems and

institutions impact the lives of MSM more than others. For example, discrimination of gay people is an accepted norm for certain religious institutions. Stigmatization of people living with HIV is an accepted norm in many institutions. Most health care and mental health and substance abuse service systems have a norm of not being gay-friendly in concrete and visible ways. In many cases, norms influence whether or not a person can and will access necessary services that would support HIV prevention behaviors.

Key MSM needs assessment findings

Based on the 2006 CPG Needs Assessment Report for MSM, an MSM behavioral surveillance pilot, and epidemiological information, important evidence concerning HIV infection among MSM has been identified. Epidemiological evidence clearly identifies that MSM risk continues to be the greatest risk factor for HIV infection in Maine. While the number of new diagnoses remained level for the period 2001-2005, the number of diagnoses among MSM increased. New HIV diagnoses among MSM are predominantly among White males between the ages of 30 – 49 years. STD data indicate that MSM engage in behaviors that put them at risk for HIV infection and/or reinfection.

During the period 2002-2006, Southern and Central Maine experienced the biggest proportion of new diagnoses. During the same time, the population centers of Portland (30%), Lewiston-Auburn (11%), Augusta-Waterville (10%), and Bangor (6%) accounted for 57% of new diagnoses among MSM.

Needs assessment evidence identifies that while MSM are, on average, informed about HIV and risk, significant rates of risk behaviors exist. In the CPG Needs Assessment Report of 2006 involving 263 MSM, almost 30% reported never using a condom for receptive anal intercourse, the highest known risk for infection. In a 2007 behavioral surveillance report among MSM in high-risk venues, between 50% and 61% reported unprotected anal sex.

The most frequently reported factors associated with not using condoms were: drinking alcohol, the feeling that condoms reduce pleasure, younger age, and anal sex with a steady or primary partner.

There were some differences among MSM based on their age. Younger MSM were more likely to report trading sex for money, shelter or drugs and less likely to report talking with casual partners about HIV. The Internet was the most frequently reported meeting locations for sex partners among younger MSM. They were more likely to report receiving STD treatment and Hepatitis A and B vaccination. Finally, younger MSM reported wanting HIV testing to be more mainstreamed as a part of routine medical care instead of targeted to high-risk groups.

There were also some differences among MSM based on race and ethnicity. Non-white MSM reported access to HIV prevention services to be more problematic. Non-white MSM were less likely to report being concerned about HIV and more likely to report believing that new drugs lessened the concern about HIV. Non-white MSM were more

likely to report having sex with an injection drug user. Native American MSM reported the Internet as the most frequent meeting location for sex partners and reported wanting off-reservation HIV prevention services.

Based on review of needs assessment data and member expertise, the following is a list of critical needs that exist for this population. These needs are directly related to the factors that affect risk mentioned above and may be useful in designing interventions. They are not listed in order of priority.

- Attitudes, beliefs, and feelings about HIV and sex
- Motivation, intention and commitment to prevent HIV infection
- Behaviors that reduce the risk of HIV infection
 - Unprotected anal intercourse
 - Number of sexual partners
- Access to protective sex devices and supplies
- Partner communication skills related to preventing HIV transmission including talking about protected sex, refusing to participate in unprotected sex, and disclosure of HIV status.
- Problem solving, coping and decision-making skills that reduce HIV transmission.
- Knowledge about HIV and sex that is accurate and comprehensive enough to make valid and reliable decisions concerning HIV prevention
- Awareness of personal risk.
- Awareness of mental health issues and resources to address them
- Knowledge of HIV and the conditional nature of test results
- Access to HIV testing through low barrier, peer led, targeted outreach testing as well as testing in all health care settings as a routine part of health care
- Integrated understanding of important HIV, other STDs and hepatitis A, B and C information and services