

Five Key Questions and Answers Related to HIV and Co-Occurring VH and STI in Oregon:

In January 2012, the HIV/VH/STI Integrated Planning Group generated more than 40 data questions related to their committee goals of reducing new infections, increasing access to prevention and care services, improving the coordination of care and prevention services, and reducing health disparities.

In this document, the IPG membership's many questions have been grouped into five broader "key questions," and information addressing each key question is provided. The data provided in this document are not exhaustive, but provide the IPG Membership with a foundation on which we can build.

3/28/12

Key Question 1: Which communities in Oregon are most heavily burdened by HIV, and co-occurring STI, and VH?

- **Gay and bisexual men:** Gay and bisexual men comprise 2 - 4% of Oregon's population,¹ but 61% of all new HIV infections in Oregon between 2005 and 2009; an additional 9% of men reported MSM/IDU risk.
 - MSM cases more likely to receive HIV medical care and slightly less likely to have advanced disease at diagnosis compared to people who acquired HIV through other means.
 - Co-occurring STI is common among MSM living with HIV. MSM with reported HIV represented about 1 in 5 syphilis cases (19%) reported in Oregon between 2005 and 2009.
- **Black/African American men and women:** Black/African American men and women comprise 2%² of Oregon's population, and account for 6% of people living with HIV.
 - New diagnosis rates were 3.5 times higher among blacks and African Americans than for non-Hispanic whites. Foreign-born blacks comprise a third of all black or African-American HIV cases.
 - During 2005-2009, Black or African American men were less likely to identify as MSM than white men (59% vs. 72%) and more likely to report high-risk heterosexual transmission (20% vs. 2%).

¹ Oregon BRFSS: 2.7% of men report gay/bisexual sexual orientation. CDC estimates 4% of men are MSM.

² Census 2010 data. For practical purposes, population estimates may be low because 4% of Oregonians report 2 or more races.

- Black/African Americans less likely to be engaged in HIV medical care compared to non-Hispanic whites.
- **Latinos and Latinas:** People of Hispanic ethnicity comprise 12% of Oregon's population, and account for 11% of people living with HIV.
 - New infections among Hispanics are increasing. New diagnosis rates are 1.2 times higher for Hispanics than for non-Hispanic whites.
 - About a third of new HIV cases among Hispanic men reported no likely transmission category. Lack of identifiable risk factor is more common among both male and female Hispanics compared to people of other races and non-Hispanic ethnicity.
 - People of Hispanic ethnicity are more likely to be diagnosed with advanced disease and less likely to be engaged in HIV medical care compared to non-Hispanic whites.
- **People who use (or have used) injection drugs:** We don't have an exact number of how many people in Oregon use injection drugs. It's estimated that, in any given year, less than 1% of the American population age 12 and older has used a needle in the past 12 months to inject heroin, cocaine, meth, or other stimulants.³ IDU is more common among males and people ages 18-34.
 - About 1 in 5 Oregon HIV cases (19%) reported IDU either in addition to MSM or as a sole risk factor.
 - The number of reported Oregon HIV cases who report past IDU has declined substantially since 1997.
 - People with HIV who use injection drugs are more likely than others to have advanced disease at diagnosis, less likely to be engaged in HIV medical care, and have shorter survival times.
 - Among HIV cases diagnosed during 2005-2009 with IDU, at least 31% of men and 57% of women had chronic hepatitis C.
- **Overall Data on Co-Occurring HIV, STI, and VH:**
 - Rates of STI are MUCH higher among PLWH, particularly male PLWH. Rates of syphilis are 116 times higher and rates of gonorrhea are 450 times higher among PLWH than among the general population.
 - Prevalence estimates of HCV/HIV coinfection vary, depending on the data source; they range from 7% (Epi Profile, 2011) to 11% (CAREAssist 2009) to 21% (MMP, 2011).

³ National Survey on Drug Abuse & Health, 2006-2008. Annualized average of past-year IDU was .17% for the civilian, noninstitutionalized population age 12+.

- 5% of PLWH/A in Oregon are estimated to have HIV/HBV co-infection.
- **Hidden or Emerging Populations:** Some populations may not represent large numbers in the local epidemic, but may represent emerging populations of concern. Similarly, the effect of the epidemic on some populations may be “hidden” because we do not have good population data (“denominator data”) on them, and therefore, cannot calculate rates or estimate relative risk.
 - The HIV Statewide Planning Group identified two groups of concern: migrant workers and transgender populations. Both of these groups are diverse.
 - Migrant workers may face barriers to accessing HIV prevention and care services that are both structural and cultural. Some identified barriers include: language; HIV-related stigma; beliefs about health, illness, and masculinity; lack of insurance and resources for basic needs; concerns about documentation status; and lack of trust, worries about confidentiality, and negative experiences with providers.⁴
- National literature show very high HIV prevalence among transgender women: a recent meta-analysis showed 28% of MTF respondents tested positive for HIV (4 studies) and 12% self-reported a positive HIV status (18 studies).⁵ However, most of these studies included samples of trans women engaging in high-risk activity, like sex work and survival sex.
- Transgender men in two needs assessments had lower rates of HIV at 2-3%, but most studies on HIV prevalence among transgender people have excluded this population.
 - Transgender men may be more likely to engage in high risk sexual activity and have lower testing rates and knowledge of HIV than transgender women.
 - Transgender men who have sex with men (TMSM) may be at a particularly high risk and programs in Ontario and San Francisco have begun to explore the HIV prevention needs of this population.⁶
- In the Speak Out survey, which included 843 LGBTQ individuals in the Portland metropolitan area, 0 transgender respondents were HIV+ compared to 18% of male-identified respondents, and 4% of gender queer and <1% of female-identified respondents.

⁴ See Holbert et al. An Evaluation of Access and Care Delivery Barriers for Latino PLWH/A, 2009 for an overview of issues for Latino PLWH/A, including migrant workers, in the Part B region of Oregon, as well as a review of national literature.

⁵ Herbst JH, Jacobs ED, Finlayson TJ, McKleroy VS, Neumann MS, Crepaz N. 2008. Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systematic review. *AIDS Behav.* 12:1-17.

⁶ See the report “Speak Out Survey 2009: Measuring Health & Wellness among Portland’s Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Communities” for national literature citations related to transgender men and more local data on transgender health.

Key Question 2: What are the strengths and gaps in Oregon’s continuum of HIV care and HIV prevention services?

- Local data indicate that recently diagnosed people are generally able to access HIV medical care in Oregon quickly and fairly easily *once they are ready to access it*:
 - 95% of MMP participants who were diagnosed in the preceding five years entered HIV medical care within 3 months of testing positive; the other 5% entered care within 3-12 months post-diagnosis.⁷
 - In a 2010 assessment, recently diagnosed HIV cases who identified as Hispanic did not report systemic barriers to HIV testing or to HIV medical care once diagnosed.
 - PLWH in the Part B area who participated in a 2011 assessment indicated that while most had been “out of care” at some point since being diagnosed with HIV, the barriers to entering or staying in care were personal rather than systemic.
- In a 2011 assessment, the main reasons PLWH in Oregon cited for being out of care—some for periods of 1 to 15 years post-diagnosis—included denial and depression, side effects of HIV medications or fear of starting medications, and alcohol and drug abuse. A few clients mentioned that issues with their doctor caused them to fall out of care.
 - These findings are consistent with the scientific literature related to why PLWH are out of care.
 - The two main reasons Oregon PLWH gave for entering or re-entering HIV medical care were being forced into care because of illness and getting connected through the efforts of a family member, friend, or another individual who reached out.
- Surveillance data show that about 25% of PLWH/A in Oregon may be out of care. People more likely to have no past-year CD4 or VL data include:
 - People with AIDS (vs. HIV)
 - Hispanics, Native Americans, Black/African Americans (vs. white, non-Hispanics)
 - MSM/IDU or IDU males (vs. MSM only) and IDU females (vs. females with heterosexual transmission risk)
 - Rural (vs. urban)
 - Foreign-born (vs. native born)
- CAREAssist (Oregon’s AIDS Drug Assistance Program, ADAP) and the Oregon Medical Insurance Pool (OMIP) provide low-income PLWH in Oregon with health insurance and access to antiretrovirals and other needed medicines. Currently, there is no ADAP waiting list in Oregon.
 - Health reforms at the national level and in Oregon will create changes in Oregon’s health care landscape that may affect HIV care & delivery. These changes need to be monitored carefully.

⁷ Nationally, 72% of PLWH entered HIV medical care within 4 months of diagnosis. (Marks, Gardner, Craw & Crepaz. 2010. Entry and retention in medical care among HIV-diagnosed persons: a meta-analysis. AIDS; 24 (17), 2665-78.

- Rural clients in Oregon report barriers to ongoing HIV medical care related to long distances between home and HIV doctor and/or specialty care, as well as stigma and lack of culturally competent medical services in rural areas.
- Hispanic respondents commonly identified fear of rejection or HIV stigma as a barrier to status disclosure, once diagnosed. Stigma is likely to also affect HIV testing practices.
- Even among PLWH engaged in HIV medical care, about 1 in 10 report unstable housing:
 - 11% of MMP participants reported moving more than once in the past year, 6% reported past-year homelessness, and 4% reported incarceration, which can often lead to homelessness or unstable housing once released.
 - In 2009, 13% of CAREAssist clients said they had considered themselves homeless in the past two years.
- About 2 in 3 MMP participants (66%) said they travel 30 minutes or less each way to get to HIV medical care. About 1 in 10 said their 1-way trip to HIV medical care is 1 hour or more.
 - But distances varied greatly, from 1-300 miles each way.
 - About 1 in 9 MMP participants said travel to HIV medical care is difficult: 10% said it was “somewhat difficult” and 4% said it is “very difficult.”

Key Question 3: What interventions and services can be used to meet the prevention and service needs of the most marginalized and highest risk groups?

- It is estimated that 25% of infected people do not know their HIV status. People with delayed diagnosis (sometimes called “late testers”) may give us a clue about who these people are.
- In Oregon, about 40% of the 1,380 cases diagnosed during 2004-2008 had delayed diagnosis.⁸ People with delayed diagnosis were more likely to be:
 - Hispanics (vs. non-Hispanic whites)
 - Men with IDU or unknown HIV transmission risk (vs. MSM)
 - Rural residence (vs. urban)
 - Older people—over age 40, with relative risk of late diagnosis highest among those age 60+ (vs. people < age 40)
- Five recent studies on reasons for delayed HIV diagnosis found that people didn’t test because they didn’t think they were at risk.
 - Samples included late testers in NYC, San Francisco, the Southeastern U.S., the UK, and MSM in Seattle.
 - Other barriers were fear of illness and dying, stigma, and beliefs that their behaviors kept them safe.
 - Two studies also looked at access issues & concluded that access to care did not seem to be the primary cause of delayed diagnosis.
- The Community PROMISE assessment in the Portland tri-county area asked 2 questions (in 2006): “what behaviors are putting MSM at risk of HIV transmission and acquisition?” and “how do men engaging in these behaviors make their sexual decisions?”
 - Mixed methods assessment included survey, in-depth interviews, focus groups, and data & literature review.
 - 1 in 10 MSM having UPAI with man of opposite or unknown HIV serostatus; high number of casual/anonymous partners; mixing of social and sexual networks.
 - Lack of communication fueled confusion about HIV status and indecision about condom use.

⁸ People with delayed diagnosis either had AIDS at the time of their initial HIV diagnosis or they progressed to AIDS within 12 months of initial HIV diagnosis.

- Both HIV+ and HIV- men often believed they were serosorting in the absence of any evidence about the other person's status.
- Highest risk men knew what behaviors were risky, but held personal narratives that let them believe their behavior was safe (e.g., belief they were serosorting) or that safer sex was the responsibility of the other partner (e.g., because of HIV status or position).
- Prevalence of HIV among incarcerated population is about 3 times higher than general U.S. population.
 - At year end 2008, 1.5% (20,075) of male inmates and 1.9% (1,912) of female inmates held in state or federal prisons were HIV positive or had confirmed AIDS.⁹
 - About 4% of MMP participants reported past-year incarceration.
 - Incarceration can disrupt HIV treatment, cause breaks in insurance, and create instability in housing, and social and familial relationships.

⁹ Maruschak L (2009). HIV in Prisons, 2007-2008. Bureau of Justice Statistics Bulletin. NCJ 228307.

Key Question 4: What are evidence-based approaches to reduce HIV/STI and HIV/VH?

- Both HIV Prevention and HIV Care Services have limits on how funding can be spent.
 - CDC requires that at least 75% of HIV Prevention funds are spent statewide on HIV testing, prevention with positives, policy work, and condom distribution; the other 25% can be spent on recommended evidence-based prevention activities to meet local needs.
 - HRSA requires that at least 75% of funds are spent on “core services,” which include a wide range of medical and dental services, including health insurance premium assistance, medical case management, substance abuse treatment, and mental health services. Supportive services may comprise up to 25% of the budget; these include services like housing assistance, medical transportation, and non-medical case management.
- Syringe exchange is effective for preventing transmission of HIV and other blood-borne diseases.
 - Syringe access is key—many studies link increased options for syringe acquisition & distribution to safer behavior. Some means of increasing access include: policies that promote wider distribution, secondary exchange, peer outreach models.
 - Clean syringes are available from Oregon pharmacies, but barriers to access for PWID exist, including pharmacist refusal to sell needles without a prescription, limiting needle sales to large quantities/cost, and stigma.
 - NYC study indicates that PWID who obtain needles from syringe exchange, pharmacies, or other sources may be different, with those not using SEP at higher risk of reusing needles.¹⁰
 - Recent multi-site (including OHSU) study with PWID in community treatment programs found syringe sharing was prevalent among that population, and awareness of HCV+ status was associated with increased risky syringe sharing behavior.¹¹ Previous studies showed mixed results re: association of HCV status and syringe sharing.

¹⁰ Rudolph AE, Crawford ND, Ompad DC, Benjamin EO, Stern RJ, & Fuller CM. (2010). Comparison of injection drug users accessing syringes from pharmacies, syringe exchange programs, and other syringe sources to inform targeted HIV prevention and intervention strategies. *Journal of the American Pharmacists Association : JAPhA*. 50(2), 140-7.

¹¹ Korthuis PT, Feaster DJ, Gomez ZL, Das M, Tross S, Wiest K, Douaihy A, Mandler RN, Sorensen JL, Colfax G, McCarty D, Cohen SE, Penn PE, Lape D, & Metsch LR. (2012). Injection behaviors among injection drug users in treatment: The role of hepatitis C awareness. *Addictive Behaviors*. 37(4), 552-5.

- Outreach models shown to increase engagement and retention in HIV medical care.^{12, 13}
 - Outreach models are labor-intensive and many cost a lot to implement.
 - Peer-based programs show promise for access to care, as well as HIV prevention among IDUs. They can also be administratively complex and costly to sustain; may require shift in thinking/political acceptance.
- HIV and Stigma: 1,368 articles came up in a recent Medline search; there was wide variation in how stigma is defined.
 - Meta-analyses found correlation between high stigma and low social support, poor physical health, poor mental health, younger age, and lower income. People with high levels of perceived stigma also were less likely to disclose their HIV status.^{14,15}
- Systematic review conducted in 2011 found that very few evidence-based interventions that are effective in reducing HIV/AIDS stigma: only 2 studies out of hundreds were considered good quality and effective.¹⁶
 - Strategies to reduce stigma include informational approaches, skill-building, counseling/support, and PLWH/A testimonials.¹⁷

¹² Bradford JB. (2007). The promise of outreach for engaging and retaining out-of-care persons in HIV medical care. *AIDS Patient Care and STDs*. 21, S85-91.

¹³ Cabral HJ, Tobias C, Rajabiun S, et al. (2007). Outreach program contacts: do they increase the likelihood of engagement and retention in HIV primary care for hard-to-reach patients? *AIDS Patient Care and STDs*. 21, S59-67.

¹⁴ Smith R, Rossetto K, & Peterson BL. (2008). A meta-analysis of disclosure of one's HIV-positive status, stigma and social support. *AIDS Care*. 20(10), 1266-75.

¹⁵ Logie C, & Gadalla TM. (2009). Meta-analysis of health and demographic correlates of stigma towards people living with HIV. *AIDS Care*. 21(6), 742-53.

¹⁶ Sengupta S, Banks B, Jonas D, Miles MS, & Smith GC. (2011). HIV interventions to reduce HIV/AIDS stigma: a systematic review. *AIDS and Behavior*. 15(6), 1075-87.

¹⁷ Brown L, Macintyre K, Trujillo L. (2003). Interventions to reduce HIV/AIDS Stigma: What have we learned? *AIDS Educ Prev*, 15: 49-69.

Key Questions 5 (&5b): What partnerships exist in Oregon to address the identified service and prevention needs and gaps? What partnerships are lacking in Oregon?

- The Coordination Committee is working on this issue. This piece will be filled in as the planning process progresses. Key agencies identified in the National HIV/AIDS Strategy give an idea of the types of partnerships that could help address prevention and service needs and gaps. These include:
 - Department of Health & Human Services
 - Department of Housing & Urban Development
 - Department of Justice
 - Department of Labor
 - Veteran's Administration
 - Social Security Administration