

# Experiences with CVCT for MSM in the United States

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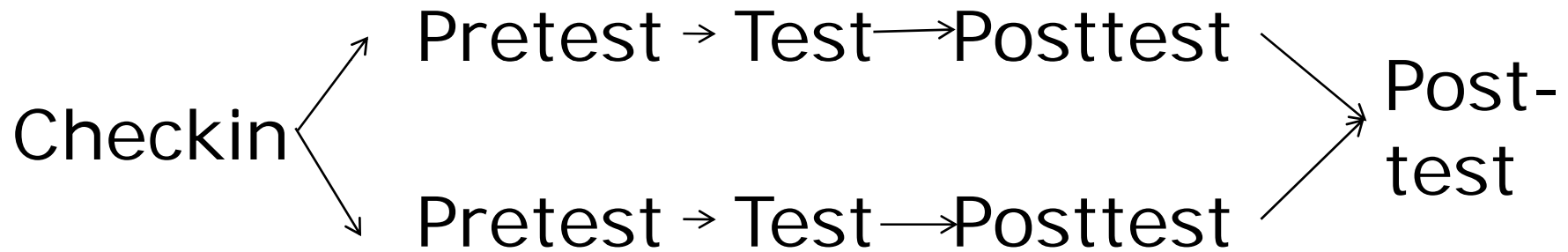
# Historical context for individual testing

- ➔ Early in epidemic: concentrated in MSM
- ➔ Concerns about confidentiality:
  - Loss of employment
  - Criminalization of male-male sex
  - Loss of insurance
- ➔ Advocacy organizations emphasized strongly absolute confidentiality

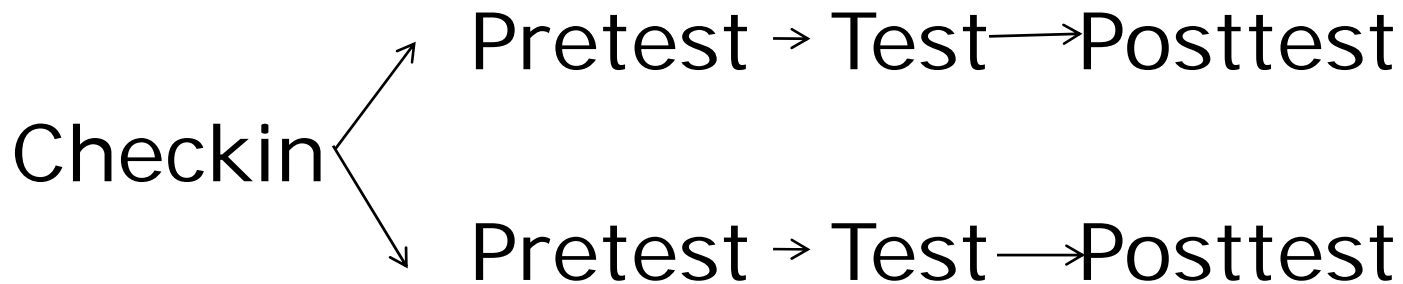
## Historical context for individual testing (2)

- ➡ More recently, HIPPA requirements
- ➡ Despite increases in legal protections, attitudes towards couples testing together have not changed
- ➡ Yet, couples seek out testing together (with anecdotal frequency)

# How is this handled currently?



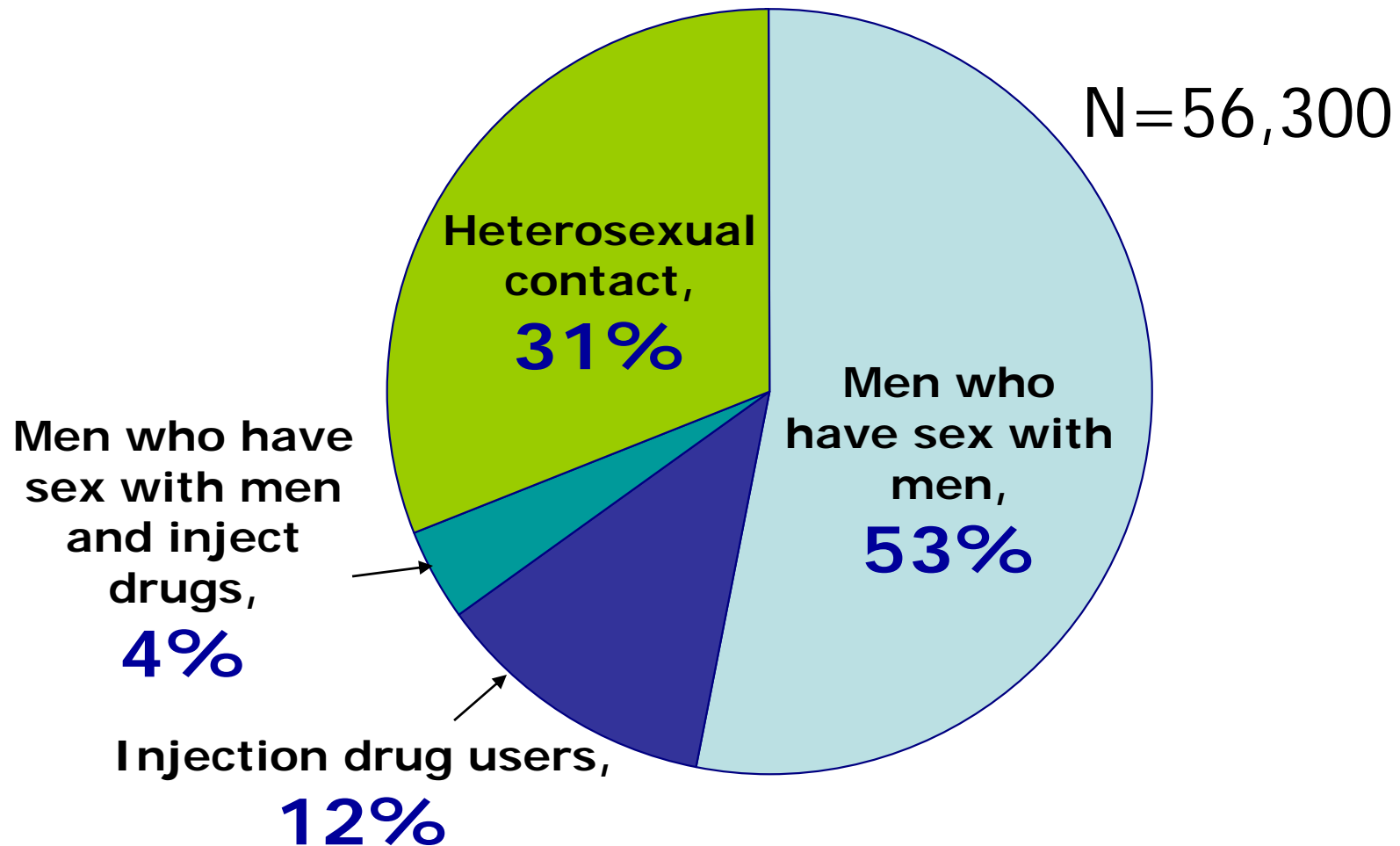
Or, more commonly:



# Reasons to consider CVCT for US MSM

- ⇒ Most heavily impacted risk group in the US
- ⇒ Endemicity within population
  - 25% prevalence in 5 US cities
- ⇒ Despite high testing, low knowledge of serostatus
  - 48% of HIV+ were undiagnosed
- ⇒ High HIV incidence: 2.5-2.9%/year
- ⇒ Most transmissions in MSM are from main partners

# Estimated percentage of new HIV Infections, by Transmission Category, 2006\*



\*50 States and District of Columbia

# Dunkle et al, Lancet 2008

- ➔ 70%-94% of new infections in Kigali and Lusaka occur from cohabiting sex partners
- ➔ CVCT could prevent 36%-70% of new infections in these cities

Articles

## New heterosexually transmitted HIV infections in married or cohabiting couples in urban Zambia and Rwanda: an analysis of survey and clinical data



*Kristin L Dunkle, Rob Stephenson, Etienne Karita, Elwyn Chomba, Kayitesi Kayitenkore, Cheswa Vwalika, Lauren Greenberg, Susan Allen*

### Summary

**Background** Sub-Saharan Africa has a high rate of HIV infection, most of which is attributable to heterosexual transmission. Few attempts have been made to assess the extent of HIV transmission within marriages, and HIV-prevention efforts remain focused on abstinence and non-marital sex. We aimed to estimate the proportion of heterosexual transmission of HIV which occurs within married or cohabiting couples in urban Zambia and Rwanda each year.

**Methods** We used population-based data from Demographic and Health Surveys (DHS) on heterosexual behaviour in Zambia in 2001-02 and in Rwanda in 2005. We also used data on the HIV serostatus of married or cohabiting couples and non-cohabiting couples that was collected through a voluntary counselling and testing service for urban couples in Lusaka, in Zambia, and Kigali, in Rwanda. We estimated the probability that an individual would acquire an incident HIV infection from a cohabiting or non-cohabiting sexual partner, and then the proportion of total heterosexual HIV transmission which occurs within married or cohabiting couples in these settings each year.

*Lancet 2008; 371: 2183-91*  
See [Comment](#) page 2148  
Department of Behavioral Sciences and Health Education and Emory Center for AIDS Research, Rollins School of Public Health, Emory University, Atlanta, Georgia, USA (K L Dunkle PhD); Hubert Department of Global Health, Rollins School of Public Health, Emory University, Atlanta, Georgia, USA  
(R Stephenson PhD, L Greenberg MPH, S Allen MD)

# Davidovich: JAIDS 2001

## Increase in the share of steady partners as a source of HIV infection: a 17-year study of seroconversion among gay men

Udi Davidovich<sup>a</sup>, John de Wit<sup>a,b</sup>, Nel Albrecht<sup>a</sup>, Ronald Geskus<sup>a</sup>, Wolfgang Stroebe<sup>b</sup> and Roel Coutinho<sup>a</sup>

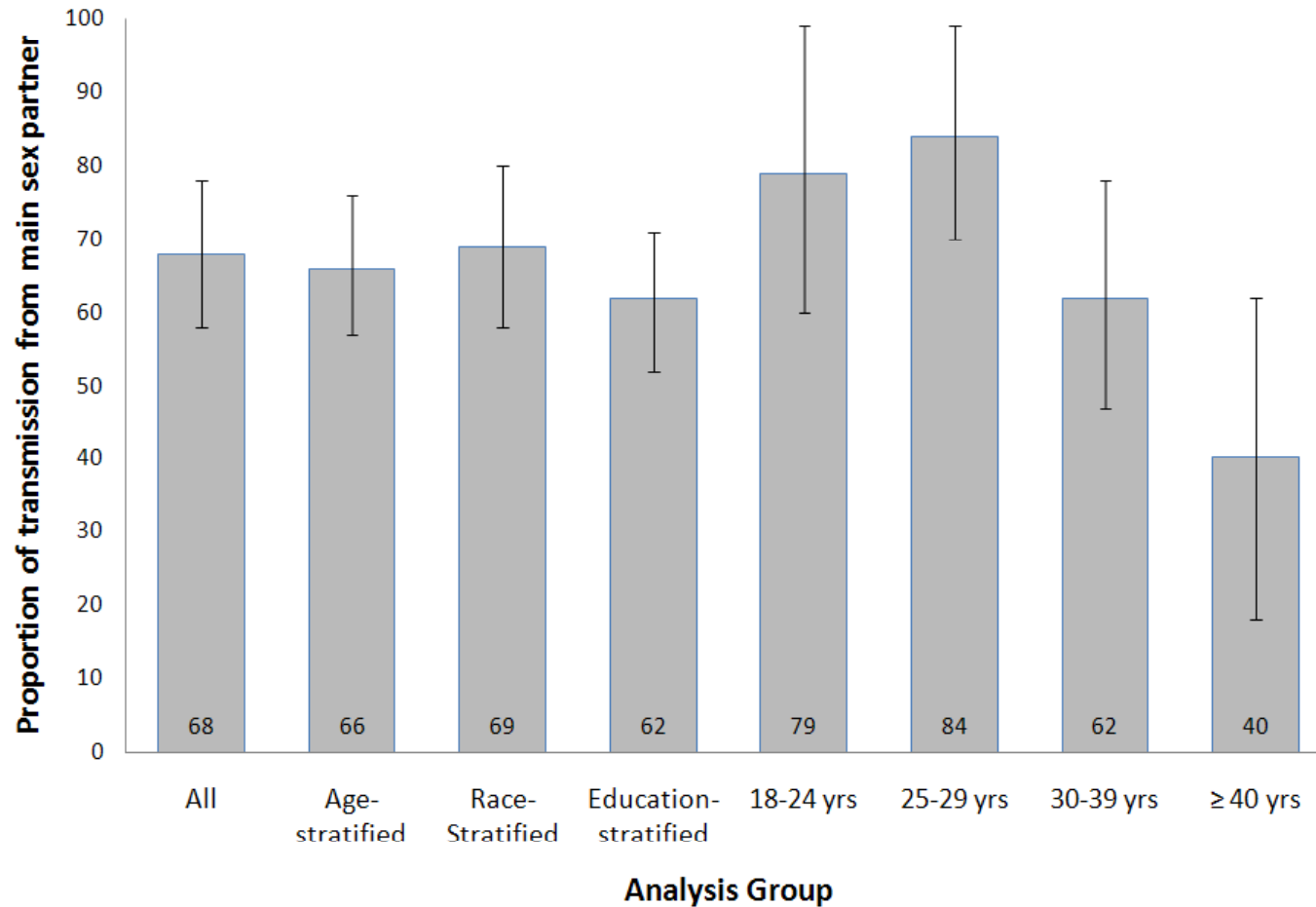
**Objectives:** To examine the share of steady versus casual partners as the source of HIV infection in gay male seroconversions between 1984 and 2000 and the effect of age at seroconversion on the source of HIV transmission.

**Methods:** The sample consisted of 144 seroconvertors from the Amsterdam Cohort Study among Homosexual Men. Questionnaires and post-seroconversion interviews were used to determine the source of HIV transmission.

**Results:** Analysis revealed an interaction effect between calendar year and age at seroconversion ( $P < 0.05$ ). Younger seroconverters had higher odds ratios [odds ratio, 11.33; 95% confidence interval, 1.77–72.13] to be infected by their steady partner late in the AIDS epidemic: 15% (three of 20) between 1984 and 1987 versus 67% (six

- ➔ Based on a cohort of HIV-negative MSM who seroconverted
- ➔ 1984-1987: 15% from steady partners
- ➔ 1994-2000: 67%

# Results – Transmissions from main partners



# CVCT for MSM: Qualitative work

- ⇒ 4 focus groups (Chicago, Seattle, Atlanta)
- ⇒ Topics relate to HIV testing experiences and barriers/facilitators to couples testing
- ⇒ Preliminary analysis

# US MSM preliminary qual data

- ➔ MSM open to the idea of couples testing
- ➔ See testing as a milestone in relationship (similar to “blood tests” for marriage)
- ➔ Some prefer separate pre-test counseling
- ➔ Believe that couples testing would reduce risk-taking in relationships
- ➔ Have used HIV testing with partner as a way to disclose serostatus

# CVCT willingness -- MSM

- ⇒ Local questions in Atlanta, Chicago
- ⇒ Theoretical likelihood to test with a partner in next year if available
- ⇒ Reasons for intending to or not intending to test with partner

## CVCT willingness -- MSM

- ⇒ 220 respondents in Atlanta, 322 in Chicago
- ⇒ 520/542 responded to CVCT willingness questions
- ⇒ 59% definitely or probably would test with a partner in the next year

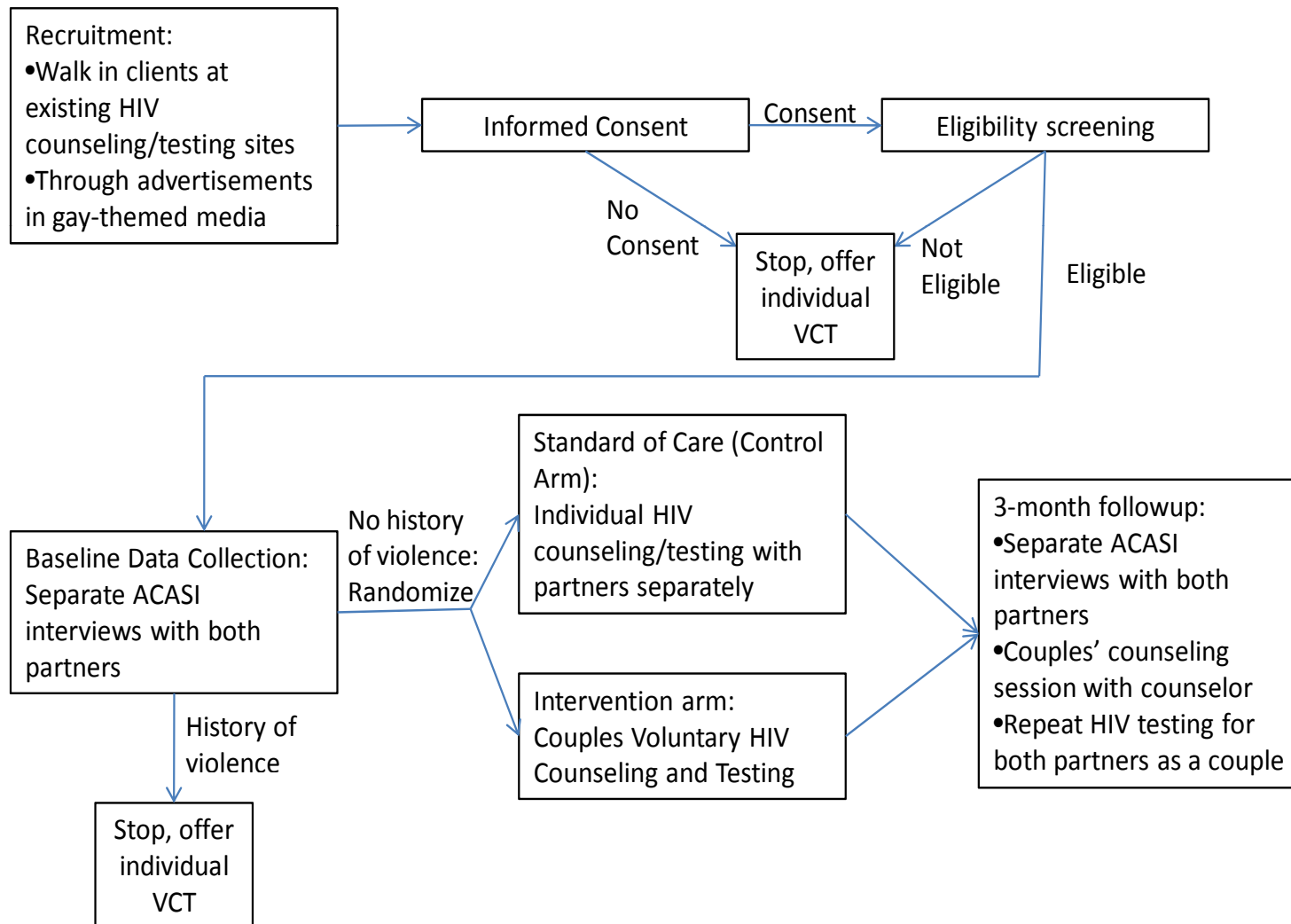
# CVCT willingness -- MSM

- ➔ Most common main reasons reported for using CVCT:
  - “we would both know where we stood” (105 [33% of respondents])
  - “to support each other” (42 [13%])
  - “would strengthen us as a couple” (29 [9%])
- ➔ Most common main reasons reported for not using CVCT:
  - “I would rather learn my own status first, then tell my partner” (134 [68%])
  - “the counselor could ask me questions I wouldn’t want to answer” (34 [17%])

## Next Steps

- ⇒ Chicago Health Department:  
funded to implement CVCT in MSM  
in health department CVT centers
- ⇒ Ongoing development of scales for  
theory-based parameters
- ⇒ Proposing satellite meeting for  
MSM CVCT around IAS conference  
(Capetown, July 2009)

# Study flow – feasibility trial



# MSM: What's the same, what's different?

## Same

- ➔ Same subtypes of couples: reuniting, pre-sexual, long-term cohabiting, pre-"marital", interracial/intercultural
- ➔ Same kinds of confidentiality concerns
- ➔ Same logistical challenges
- ➔ Power dynamics within the couple
- ➔ Disclosure

## Different

- ➔ Testing occurs in the context of societal homophobia
- ➔ More partners with concurrent sex partners than M-F couples
- ➔ Mixed male and female sex partners – double disclosure??
- ➔ Different sexual roles – choices have been suggested as prevention strategies

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