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TO AVOID SOCIAL ISOLATION, DISCRIMINATION, or verbal or physical abuse, many men who have sex with men (MSM), especially young and minority MSM, do not disclose their sexual orientation.1,2 Young MSM who do not disclose their sexual orientation (non-disclosers) are thought to be at particularly high risk for human immunodeficiency virus (HIV) infection because of low self-esteem, depression, or lack of peer support and prevention services that are available to MSM who are more open about their sexuality (disclosers).1,3 However, the risks for HIV infection and other sexually transmitted diseases (STDs) are unknown for non-disclosers. To better understand the prevention needs of young MSM, CDC analyzed data from the Young Men’s Survey (YMS) to compare HIV/STD risk differences between nondisclosers and disclosers. This report summarizes the results of that analysis, which indicate that 8% of 637 nondisclosers were infected with HIV compared with 11% of 4,952 disclosers. Among blacks, the prevalence of HIV infection was 14% among 199 nondisclosers compared with 24% among 910 disclosers. Compared with disclosers, nondisclosers had similar high risks for other STDs, reported less sexual behavior with men and more sexual behavior with women, and more sexual behavior with women, compared with disclosers, nondisclosers had similar high risks for other STDs, reported less use of HIV testing services, and, among those who were HIV infected, were less likely to be aware of their infection. To reduce HIV/STD transmission among young MSM and their female sex partners, comprehensive HIV/STD testing and prevention programs for young nondisclosers, especially for those who are black, should be developed or expanded.

YMS was a cross-sectional survey conducted during 1994-2000 of men aged 15-29 years who attended MSM-identified venues in six U.S. metropolitan areas (Baltimore, Maryland; Dallas, Texas; Los Angeles, California; Miami, Florida; New York, New York; and Seattle, Washington).1,2 Participants were interviewed with a standard questionnaire, had blood drawn for testing, and were provided HIV/STD prevention counseling and referral for care. Specimens were tested for HIV and hepatitis B virus (HBV) with standard assays. HBV infection was defined as the presence of HBV surface antigen or antibodies to HBV core antigen.

Disclosure was assessed with the following measure: “Using this card, choose the number that best describes how ‘out’ you currently are about having sex with men. By ‘out,’ we mean you let others know that you are sexually attracted to men.” Responses were measured on a 7-point scale (e.g., 1, “Not out to anyone”; 7, “Out to everyone”). Participants who answered 1 or 2 were defined as nondisclosers, and participants who answered 3-7 were defined as disclosers. Participants who answered 1 or 2 were grouped together because of similarities in their demographic characteristics, reported risk behaviors, and prevalence of HIV infection. Differences between nondisclosers and disclosers were evaluated by using the Cochran-Mantel-Haenszel chi-square test controlling for city, age group, and race/ethnicity (if applicable). Analyses were stratified by race/ethnicity for those groups that had ≥50 nondisclosers. Some analyses were restricted to men aged 15-22 years because YMS was conducted in two different phases, and some questions were not repeated in the second phase, which was conducted among men aged 23-29 years.

In the six cities, 5,589 MSM participated in YMS (range by city: 815-1,060). The participation rate among eligible men was 59% (range: 54%-66%). A total of 637 (11%) MSM were defined as nondisclosers (range: 7%-14%); of these, 349 (55%) were aged 15-22 years (median: 22 years; interquartile range: 19-25 years). Black (18%), mixed-race (14%), Hispanic (13%), and Asian/Pacific Islander (10%) MSM were more likely to be nondisclosers than were white MSM (8%) (p<0.05). Among racial/ethnic minorities, age was not associated with nondisclosure. However, among white MSM, the proportion of nondisclosers decreased with age: 12% among those aged 15-19 years, 8% among those aged 20-24 years, and 5% among those aged 25-29 years (p<0.01).

Nondisclosers were less likely than disclosers to identify themselves as homosexual and to attend homosexually identified bars and dance clubs (p<0.05), although 64% of nondisclosers attended these venues at least monthly. Among MSM aged 15-22 years, nondisclosers were more likely to report that being homosexual or bisexual or having homosexual or bisexual friends was not important, that they sometimes disliked themselves for being homosexual or bisexual, that they felt isolated from others, and that the majority of persons in their racial/ethnic group disapproved of homosexuals (p<0.05).

The 637 nondisclosing MSM reported a median of five male (interquartile range: 2-13) and three female (interquartile range: 1-12) sex partners during their lifetime. During the preceding 6 months, 212 (33%) reported having unprotected anal iner-
course (UAI) with men, and 169 (27%) reported having unprotected vaginal or anal intercourse (UI) with women. For all racial/ethnic groups, nondisclosers reported less sexual behavior with men and more sexual behavior with women (p<0.05). Similar high proportions of disclosers and nondisclosers reported perceiving themselves to be at low risk for HIV infection and using a regular source of health care; however, proportionally fewer (p<0.05) nondisclosers had ever or repeatedly (≥3 times) tested for HIV. Nondisclosers reported a median of only one previous HIV test (interquartile range: 0-2); 60% had either never tested previously or had not tested in >1 year.

No differences were observed in the high prevalence of HBV infection and self-reported previous STDs between disclosers and nondisclosers; however, the prevalence of HIV infection was lower among nondisclosers than disclosers (adjusted odds ratio [AOR]=0.5; confidence interval [CI]=0.4-0.7). Among nondisclosers, the prevalence of HIV infection was higher among blacks than all other racial/ethnic groups combined (14% versus 5% [AOR=2.9; CI=1.5-5.6]). However, black nondisclosers were more likely to perceive themselves to be at low risk for ever acquiring HIV compared with all other nondisclosers (68% versus 56%; p<0.01). Similar proportions of HIV-infected nondisclosers (n=51) and disclosers (n=522) reported engaging in UAI with male partners during the preceding 6 months (51% versus 50%) and injecting drugs during their lifetime (8% versus 12%). HIV-infected nondisclosers were more likely than disclosers to report being unaware of their infection (98% versus 75%; p<0.01), and during the preceding 6 months, having one or more female sex partners (35% versus 10%; p<0.01) and engaging in UI with female sex partners (20% versus 5%; p=0.01).

The findings that more than one in three nondisclosers reported having recent female sex partners suggests that nondisclosing MSM might have an important role in HIV/STD transmission to women. This might be particularly true for black nondisclosing MSM, of whom approximately one in five was infected with HBV and one in seven was infected with HIV. To help prevent further HIV/STD transmission among young MSM and their female sex partners, greater efforts are needed to increase public awareness and to develop or expand HIV/STD testing and prevention programs to meet the needs of nondisclosers, particularly those who are black.

The findings in this report suggest that public-awareness and prevention programs should be developed for nondisclosing MSM to reduce internalized homophobia and other factors that influence nondisclosure, barriers to HIV/STD testing and prevention services, low-risk perception, and high-risk behavior, including the risk for transmission to male and female sex partners. Corresponding efforts also should be developed for women to increase knowledge of HIV/STD acquisition risks from partners who might be bisexual and of where to obtain confidential testing and prevention services for themselves and their partners.

Prevention managers should intensify outreach efforts to provide HIV/STD testing, risk reduction, and health-care referral services to nondisclosers who avoid homosexually identified prevention organizations. Because this report and others9 suggest that many nondisclosers have regular male and female sex partners, prevention managers should consider combining outreach efforts with partner counseling and referral services8 and community network development strategies8 to increase the availability of HIV/STD prevention services to sex partners of nondisclosing MSM.

In accordance with recently revised guidelines, health-care providers should routinely assess the HIV/STD risks of their patients and encourage at-risk MSM to test annually for HIV, syphilis, gonorrhea, and chlamydia, and to accept or seek vaccination against hepatitis A and B.9 To facilitate risk disclosure from young MSM, health-care providers should create discrete and nonjudgmental environments and ensure that patients are aware of confidentiality safeguards and of the importance of disclosing accurate risk information.3

The findings in this report are subject to at least three limitations. First, information about the types of persons to whom disclosure was provided or withheld was not collected routinely. Second, the percentage of young MSM defined as nondisclosers in this report should be considered a minimum estimate because young MSM who are reluctant to disclose their sexual orientation were probably less likely to participate or report sexual behavior with men. Finally, findings might not be applicable to nondisclosing MSM aged >29 years or to MSM aged 15-29 years who do not attend MSM-identified venues or reside in one of the six participating cities.

The finding that all but one HIV-infected nondiscloser were unaware of their infection is consistent with a re-
cent report suggesting that the majority of young HIV-infected MSM do not know they are infected.10 For more young HIV-infected MSM to realize the benefits of early diagnosis and care, and to help prevent further HIV transmission among young MSM and their female partners, health-care providers and federal, state, and local HIV-prevention managers should expand and improve HIV testing and prevention practices to meet the needs of diverse MSM, including those who do not disclose their sexual orientation.

REFERENCES

9. CDC. Sexually transmitted diseases treatment guidelines. MMWR 1999;48(No. RR-6).

Accelerated Measles Control—Cambodia, 1999-2002

MMWR. 2003;52:4-6

1 table, 1 figure omitted

Cambodia is recovering from approximately 30 years of civil war that resulted in the breakdown of the country’s public health infrastructure.1 In 1999, the Ministry of Health initiated a measles-control program with the goal of reducing the annual incidence of measles to <10,000 cases in 2005 by strengthening measles surveillance, improving routine vaccination coverage, implementing supplementary measles immunization activities (SIAs), and providing vitamin A during outbreak investigations and SIAs. This report summarizes measles-vaccination activities and their impact in reducing reported measles cases from 13,827 in 1999 to 1,234 in 2002 and suggests options for future measles-control efforts in post-conflict situations.

Routine and Supplementary Vaccination

Routine measles vaccination began at Cambodian health centers in 1986, with outreach activities added in 1990 and SIAs in 2000. The most basic organizational component of the health-care delivery system is the health center, each serving approximately 10,000 persons. Many villages lack easy access to these facilities, and only 30% of children had access to vaccination services during the early 1990s. Since 1990, outreach teams from health centers have visited villages every 4-8 weeks to deliver vaccination and other preventive health services. These outreach services helped increase coverage for measles vaccination in the country from 34% in 1990 to 75% in 1995, although coverage declined to 63% during 1998-1999, after a resurgence of civil unrest in 1997. In 2000, before the initiation of SIAs, measles vaccination coverage increased to 69% (Cambodian Ministry of Health, unpublished data, 2001).

The Cambodian National Immunization Program (NIP), in collaboration with partner agencies, initiated measles SIAs in December 2000 to vaccinate children who were missed by routine services. The initial plan was to vaccinate all children aged 9 months-5 years, regardless of previous vaccination history, in two phases. After Phase 1, the subsequent phase was expanded in 2001 to include children aged 9 months-14 years after a review of measles surveillance data indicated that approximately 50% of measles cases occurred in children aged >5 years. To avoid overextending the public health system of the country and compromising the quality of the campaign, the second phase was then divided into two (phases II and III).

Phase I, conducted during December 2000—May 2001, targeted 191,527 children aged <5 years living in remote border areas who were administered multiple vaccines (measles, oral polio vaccine [OPV], diphtheria-tetanus-pertussis vaccine), vitamin A, and mebendazole for helmint control; an 89% coverage rate with measles vaccine was attained. Phase II, conducted during October 2001—April 2002, targeted 2,489,761 children aged 9 months-14 years living in eight provinces in densely populated central areas. These children were administered measles vaccine, OPV (in selected areas), vitamin A, and mebendazole; a 97% coverage rate with measles vaccine was attained. Phase III, which began in October 2002 and will continue through April 2003, will target approximately 2,300,000 children aged 9 months-14 years living in the remaining seven provinces in central areas with measles vaccine, OPV (in selected areas), vitamin A, and mebendazole.

SIAs are conducted in a “rolling” manner, which cover one province at a time by teams comprising local, district, and provincial Expanded Program on Immunization (EPI) staff, with supervision by staff from the national program. Each district is covered in approximately 2 weeks. SIAs are preceded by social mobilization activities in which local volunteers and community leaders publicize the upcoming activities. Temporary vaccination posts operate in the mornings and are followed by house-to-house vaccination in the afternoons. House-to-house vaccination is particularly necessary in densely populated urban areas, where social mobilization might not be as effective as in villages.