M-Track Survey

Monitoring Trends in the Prevalence of HIV, Viral Hepatitis, Other Sexually Transmitted Infections, and Associated Risk Behaviours Among Gay, Bisexual, Transgendered and other Men who have Sex with Men

Phase I - Final Report
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Prepared by the Public and Population Health Observatory
Vancouver Island Health Authority

VANCOUVER ISLAND health authority

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Advisory committee members:
- Dr. Doug McGhee, Physician, Youth Clinic
- Alex McLeod, Volunteer, AIDS Vancouver Island
- Dr. Eric Roth, Professor of Anthropology, University of Victoria
- Captain Snowden, Coordinator, Gay Men's Community Development, AIDS Vancouver Island
- David Mielke, Coordinator, Gay Men's Community Development, AIDS Vancouver Island
- Michael Yoder, Consultant and former Executive Director, Victoria AIDS Resource and Community Service Society

Research Advisors:
- Dr. Mark Gilbert, Physician Epidemiologist, BC Centre for Disease Control, and Provincial Coordinator of M-Track
- Dr. Robert Hogg, Director of the HIV/AIDS Drug Treatment Program at the BC Centre for Excellence in HIV/AIDS and Professor, UBC Department of Health Care and Epidemiology

Staff and volunteers of the following agencies, clubs and organizations:
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Research Assistants:
- Murray Anderson
- Jaden Keitlah
- Dr. Josephine MacIntosh
- Alex McLeod
- Rick Meyers

Vancouver Island Health Authority:
- Dr. Richard Stanwick
- Dr. Murray Fyfe
- Mike Pennock
- Audrey Shaw
- Liz Walker
- Dana Carr
- Dr. Bridey Stirling

Public Health Agency of Canada, **Centre for Communicable Disease Prevention and Control**:
- Dr. Chris Archibald
- Dana Paquette
- Stephen Cule
- Dr. Tom Wong
- Rhonda Kropp
- Paul Sandstrom
- Dr. John Kim
- Laurie Malloch

National Microbiology Laboratory:
- Dr. Alberto Severini
- Pam Sawatzky

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EXECUTIVE SUMMARY

M-Track is a national, enhanced monitoring system designed to track changes over time in HIV, viral hepatitis, other sexually transmitted infections, and associated risk behaviours in gay, bisexual, transgendered, and other men who have sex with men. The Vancouver Island Health Authority (VIHA), in partnership with the Public Health Agency of Canada (PHAC), completed Phase I of the M-Track survey in the Greater Victoria area in the summer of 2007 after conducting a feasibility study that involved consultation with an advisory committee and members of the gay community. The purpose of this report is to disseminate the results of this survey to service providers, community organizations, and interested individuals so the information may be used to enhance services, raise awareness, and provide meaningful discussion among gay, bisexual, and transgendered men.

Between June and September 2007, 224 survey participants were recruited at Pride festival events, a gay bar, a gay camping retreat, gay community organizations, HIV/AIDS community organizations, health clinics, private events, a bathhouse, and a park, as well as through personal networks. During the three-month recruitment period, participants completed a self-administered questionnaire that included sections on demographics, sexual behaviours, drug use, disease testing, health status, heath service use, self esteem, social networks and support, experiences of prejudice, and community involvement. Of the 224 respondents, 184 men (82%) provided a dried blood spot sample to test for HIV, hepatitis C, and syphilis. Approximately 90% of the 224 participants completed a tracking code form to allow for their results to be compared across consecutive M-Track survey rounds. Results from the questionnaires and blood spot samples were entered into a secure database for analysis and reporting by PHAC and VIHA.

The survey found that 13.6% of M-Track respondents who provided a dried blood spot sample were positive for HIV. Approximately 3% of respondents had been infected with hepatitis C and syphilis, while over 30% of respondents had been infected with the herpes 2 virus, the main cause of genital herpes. When asked about sexual behaviour, three-quarters of respondents reported having had sex with a casual male partner in the past six months, and 40% of these reported having unprotected sex with a casual male partner. With regards to disease testing in the past two years, 58% of respondents had tested for HIV, and approximately one-third had tested for other sexually transmitted infections. Of the individuals who provided blood samples for this survey, 96% correctly knew their HIV status.

The majority of survey respondents indicated that they were part of queer social networks and that they had emotional and social supports available to them most of the time. Many also reported that they felt it was important to be active in the queer community. It is hoped that the information that M-Track participants provided as part of the survey will be useful to the gay, bisexual, and transgendered community for the prevention of sexual infections and the promotion of men's health and wellbeing.

The process of completing the M-Track survey built bridges between the health authority and the gay, bisexual, and transgendered community in southern Vancouver Island and the southern Gulf Islands. The development of these relationships will facilitate future rounds of M-Track along with other collaborations between VIHA and the community on initiatives to benefit the health of gay, bisexual, and transgendered men.

1.0 INTRODUCTION

1.1 Background

Human immunodeficiency virus (HIV) and hepatitis C (HCV) are bloodborne diseases that are primarily transmitted through direct contact with blood and, to a lesser extent, other body fluids. Individuals are at risk of acquiring HIV and HCV if they regularly engage in behaviours that directly expose them to blood and other body fluids, such as having unprotected sex or injecting drugs. Unprotected sex can also lead to other sexually transmitted infections (STIs).

The World Health Organization has recommended enhanced monitoring of HIV in populations that are at increased risk of exposure. This monitoring aims to understand the behaviours that precede infection as well as to track changes in the epidemic over time. Once the information is gathered, it can be translated into public health and community interventions to prevent infection or plan for care and support among those most affected.[i]

Gay, bisexual, transgendered, and other men who have sex with men (MSM) have been seriously affected by the spread of HIV/AIDS since the beginning of the epidemic in the 1980s. In Canada, MSM account for 76.1% of AIDS cases and 68.1% of positive HIV test reports among adult males since testing began.[ii] Research in the 1980s found a strong association in MSM between being HIV positive and having experienced high-risk sexual activity. Gradually, the implementation of education and prevention campaigns reduced the spread of infection of HIV, and rates of many sexually transmitted infections declined among men in the early 1990s.

Since the mid-1990s, the use of highly active antiretroviral therapies (HAART) has significantly reduced death and serious illness from HIV infection.[iii] Although HIV infection still shortens life expectancy and can lead to poor health, there has been growing optimism about HIV treatment among men who have sex with other men, which may be associated with a concurrent rise in risk behaviour. Recent data suggest that MSM continue to be at risk for HIV infection and other STIs by engaging in unprotected anal intercourse or practicing unsafe sex. Recent findings indicate that HIV infections are increasing and may continue to increase among MSM in some parts of Canada. The incidence of reportable STIs has been increasing steadily in MSM and the general Canadian population since 1997.[iv] Local outbreaks of infectious syphilis have been associated with MSM in several communities across Canada.[v]

1.2 Overview of the M-Track Survey

The Public Health Agency of Canada (PHAC) has developed a program for monitoring disease rates and associated risk behaviours in population groups that are at high risk for acquiring HIV, hepatitis C, and other sexually transmitted infections. The M-Track survey is part of this program and is aimed at learning more about HIV rates and trends in gay, bisexual, and transgendered men and other men who have sex with men. PHAC initiated preparations for M-Track in 2003, and survey recruitment started in 2005. The M-Track survey has been conducted in several cities across Canada – Montreal, Toronto, Ottawa, and Winnipeg – and will be taking place in Vancouver in 2008.

2.0 FEASIBILITY STUDY

2.1 Introduction

To determine whether the M-Track survey could be successfully completed in Victoria, the Public Health Agency of Canada funded the Vancouver Island Health Authority to conduct a feasibility study between January and March 2007. The feasibility study had three interrelated components: advisory committee coordination, completion of an environmental scan, and submission of ethical review applications.

2.2 Advisory Committee

An M-Track Advisory Committee was created to assist with the review of how M-Track might be conducted in Victoria. Potential members of the advisory committee were identified through professional networks. Individuals from the gay, bisexual, and transgendered community were invited to participate along with individuals involved in service provision and research.

Advisory committee members were asked to contribute knowledge and opinions about potential recruitment locations, recruitment methods, promotional materials and strategies, core questionnaire content, and potential questions of local interest to add to the questionnaire. The advisory committee was involved with the selection of site-specific questions asking respondents about the following: physical and mental health status, stress, main health concerns, access to health services and sexual health information, experiences of homophobia while accessing health services, experiences of prejudice or assault, self esteem, social support, relationship status, social networks, and community involvement. Many of the questions selected were drawn from the Canadian Community Health Survey (CCHS) that is used regularly by Statistics Canada to measure the health status of Canadians not living on reserves. These broader health status and social support questions were included to assess some of the social factors that can influence behaviour, and results for these questions in the M-Track survey can be compared to national data from Statistics Canada. The advisory committee was also instrumental in connecting the VIHA M-Track research team with key members of the queer community in Victoria.

Later in the project, the advisory committee met to discuss preliminary results from the analysis. They also suggested additional analysis of interest to the community and provided feedback on dissemination strategies and materials.

2.3 Environmental Scan

The objective of the environmental scan was to describe the community of gay, bisexual, transgendered and other MSM in Victoria in order to identify an appropriate sampling methodology. The sampling approach selected for M-Track in Victoria was to recruit individuals from venues associated with the gay community, as well as to recruit individuals at special events taking place in a variety of locations. The special events, such as those surrounding the Pride Parade and Festival, aimed to diversify the sample and provide an opportunity for men who didn't visit gay-specific venues to participate in the survey. The special events were also a way of increasing the number of participants in the survey beyond the number available through recruitment at gay-specific venues.

2.4 Ethical Review Process

The M-Track survey received approval by national and local ethical review boards. The M-Track protocol, questionnaire, and informed consent documents were reviewed and approved by Health Canada's Research Ethics Board and by the Health Research Ethics Board of the Vancouver Island Health Authority.

3.0 METHODS

3.1 Survey Design

M-Track is an ongoing survey that will be implemented every few years. It accesses a cross-section of the MSM population in any given year, and future rounds of the survey can include individuals who have and have not participated in previous rounds.

3.2 Target Population and Sample Size

Using EpiInfo software and data on HIV rates in MSM elsewhere in Canada, it was determined that a sample size of 330 would be required to detect the HIV prevalence rate in MSM in southern Vancouver Island. This became the target sample size, and the recruitment jurisdiction was identified as south Vancouver Island and the southern Gulf Islands.

A venue-based sampling method was used for the M-Track Victoria survey in conjunction with recruitment of participants at special events. It was unlikely that randomly sampling individuals at venues and events and inviting them to participate would have resulted in 330 individuals completing the survey in the time available for the survey round. Instead of randomly selecting individuals, a convenience sample was recruited that included any individuals who wished to participate in the survey who also met the eligibility criteria. Recruitment methods were documented to assist with replicating the sampling approach in future rounds.

3.3 Eligibility

To be eligible for the survey, the participant met the following criteria:

- Currently live, or have a residence, in southern Vancouver Island or the southern Gulf Islands (South VIHA)
- Biological or self-identifying man who has ever had sex with a biological male or self-identified man (rationale for criterion – all these individuals are potential participants in the same sexual network and are at risk for HIV/STI transmission)
- Must be 18 years of age or older
- Have not completed a survey in current cycle

3.4 Recruitment Activities

The recruitment period was approximately 12 weeks long from June 19 to Sept 13, 2007. Participants were recruited from 8 venues and 17 special events in the community, as well as through telephone appointments and personal networks of the research team. Some of the special Pride events were held at regular venues while others were in different locations and were sponsored by a person or organization in the community. This list of potential venues expanded throughout the study period through informal interviews with members of the queer community. As contact was made with various organizations, bridges were built allowing access to lower profile groups.

3.5 Confidentiality

Survey respondents were asked to provide a unique identifier – an initial and a significant date – which could be remembered for future surveys. This unique identifier was encrypted through a computer program that generates a number which cannot be traced back to the participant. The

questionnaire and the blood sample were linked only by the encrypted code, and this ensured the respondents remained anonymous.

3.6 Questionnaire

The questionnaire was self-administered by survey participants. The core components of the questionnaire, utilized across Canada, consisted of approximately 40 questions in 8 sections:

- Personal and social background
- Drug use and sex life
- Sex with casual male partners
- Sex with regular male partners
- Sex with regular HIV-positive male partners
- Sex with regular male partners of unknown HIV status
- Sex with regular HIV-negative male partners
- Sex in exchange for money, drugs or other goods or services
- Testing for HIV, hepatitis, and sexually transmitted infections

Five additional sections were added by the Victoria M-Track team based on input from the advisory committee members:

- Health status
- Access/barriers/utilization of health services
- Attitudes and social support
- Experiences of prejudice or assault
- Social networks and community involvement

3.7 Blood Specimen

A sterile lancet was used to collect a finger-prick blood sample, and the blood was preserved on a small card provided by the National Microbiology Laboratory. The blood samples were sent to the laboratory for analysis of HIV, hepatitis C, and syphilis, and if participants consented, for analysis of herpes and other sexually transmitted infections.

3.8 Local Data Analysis Approach

VIHA was provided with a clean dataset by the Public Health Agency of Canada. Local analyses were carried out using SPSS 15.0 software, and descriptive analyses were conducted on variables related to demographics, sexual behaviours, drug use, health status, health service use, attitudes towards self, social support, and interpersonal experiences.

3.9 Limitations of Data

It should be noted that the participants were not selected randomly to participate in the survey and that the survey had a limited sample size. Because of this, the results in this report should not be considered as representative of all gay, bisexual, and transgendered men in South VIHA. Rather, the results are a description of the individuals who chose to participate in the survey and cannot be generalized with any degree of certainty beyond this group. In addition, only respondents 18 years of age or older could participate, and therefore no data was collected on youth less than 18 years of age. The limitations of self-administered questionnaires (e.g., misunderstood questions) will also apply to the M-Track survey.

4.0 RESULTS

4.1 Sample Size and Recruitment Sites

Results are based on the survey data from 224 participants who completed the self-administered questionnaire and 184 who consented to provide finger-prick blood samples. Testing for herpes was conducted on 136 blood samples provided by participants who also consented to additional disease testing. Participants were recruited from 8 venues and 17 special events in the community, as well as through telephone appointments and personal networks of the research team.

4.2 Characteristics of Respondents

The survey respondents reported diverse demographic characteristics. Participants ranged in age from 18 to 75, with an average age of 40. There is a similar distribution of age groups from 18 to 54 years, though the minimum age for participation was 18 and fewer years are represented in the youngest category. There is a decrease of 15% to 20% in age groups 55 years and greater.

Respondents were able to select up to four categories when asked what culture or ancestry they identified with closely. The majority of respondents reported British ancestry, and approximately 15% reported aboriginal ancestry. Less than 10% of respondents specified the following ethnic origins: North European, South European, East European, East Asian, Other European, African, and Latin. Approximately 60% of respondents had completed some university or college or some graduate education (Masters, PhD). With regard to annual income, approximately 50% of respondents had earned below $30,000 the previous year and 50% had earned above $30,000. Demographic characteristics of respondents are summarized in Figures 4.1 to 4.3.

Figure 4.1: Distribution of respondents by age group

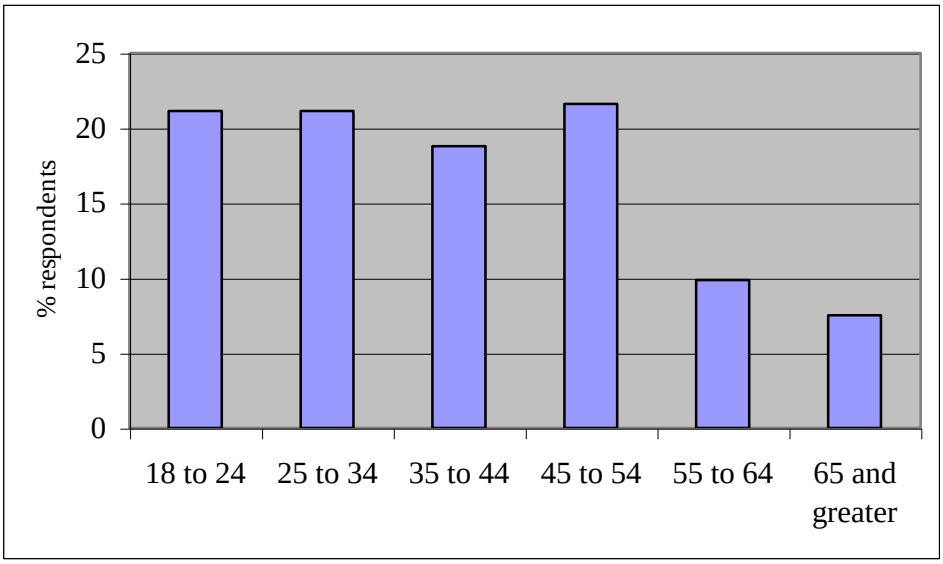


Figure 4.2: Distribution of respondents by ancestry

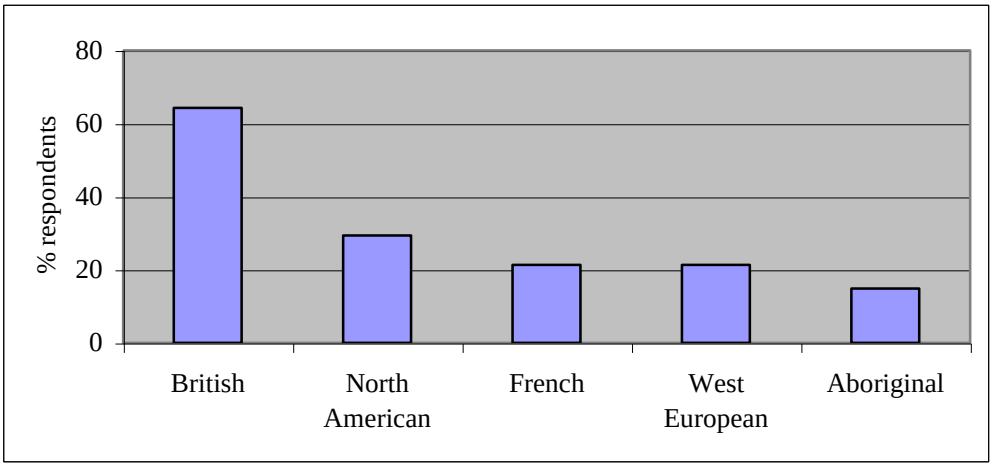
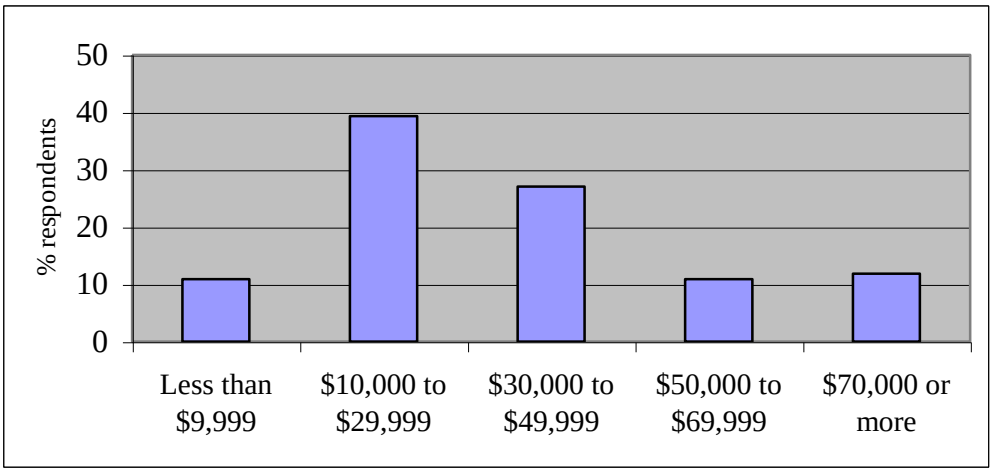


Figure 4.3: Personal income from last year, all sources, before taxes



Tables 4.4 to 4.6 present results from survey questions that asked respondents about their sexual orientation, marital status, and type of current relationship. Approximately 80% of respondents defined themselves as gay/homosexual, with another 10% identifying as bisexual. Approximately 10% defined themselves as transgendered, two-spirit, or heterosexual or as another kind of identity including combinations of those previously mentioned. Sixty percent of all respondents reported being single (never married), a category that included both dating and not dating for the purposes of this survey. Approximately 60% of respondents who were in a same sex or common-law marriage described their relationship as monogamous.

Figure 4.4: Sexual orientation of respondents

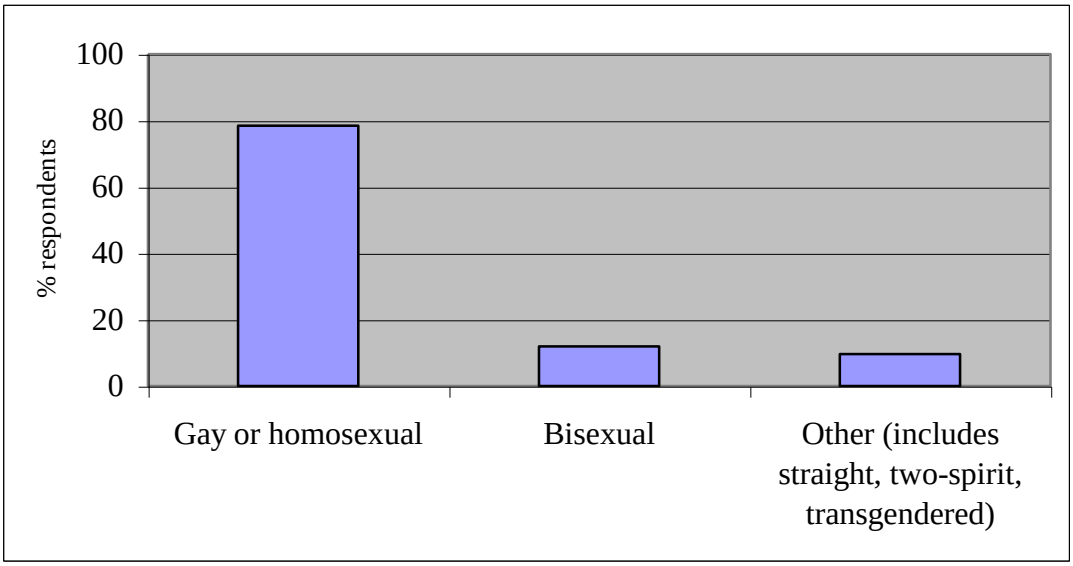


Figure 4.5: Relationship status

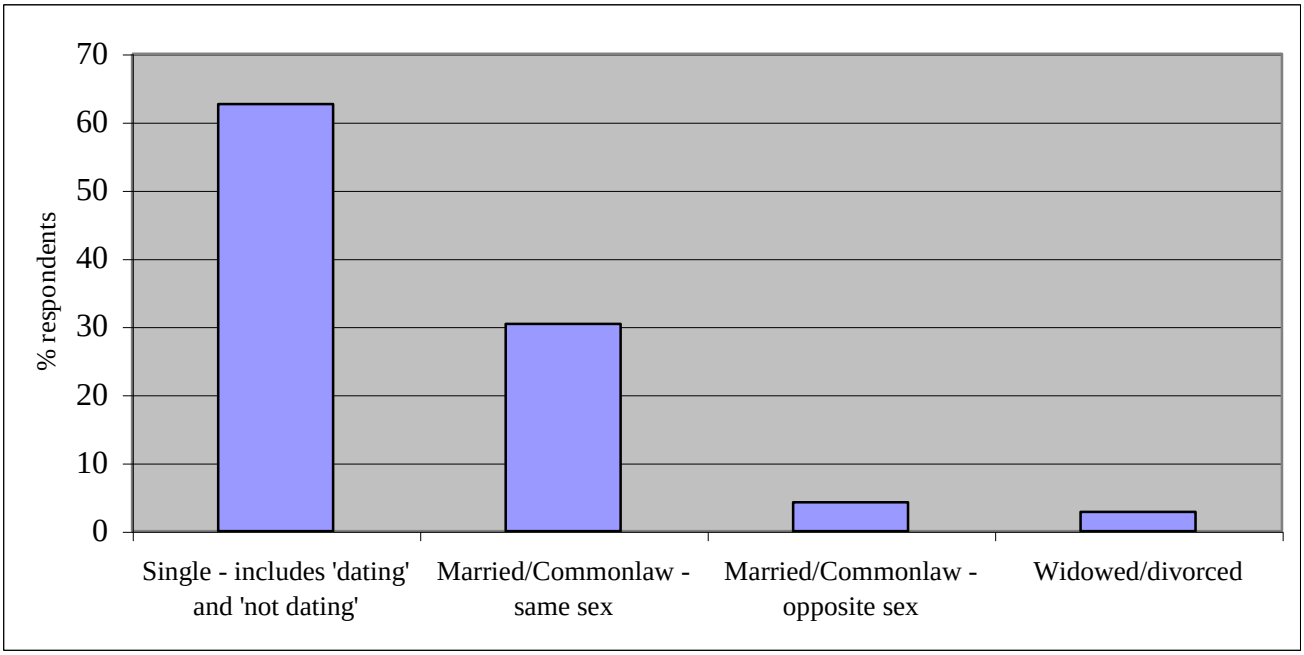
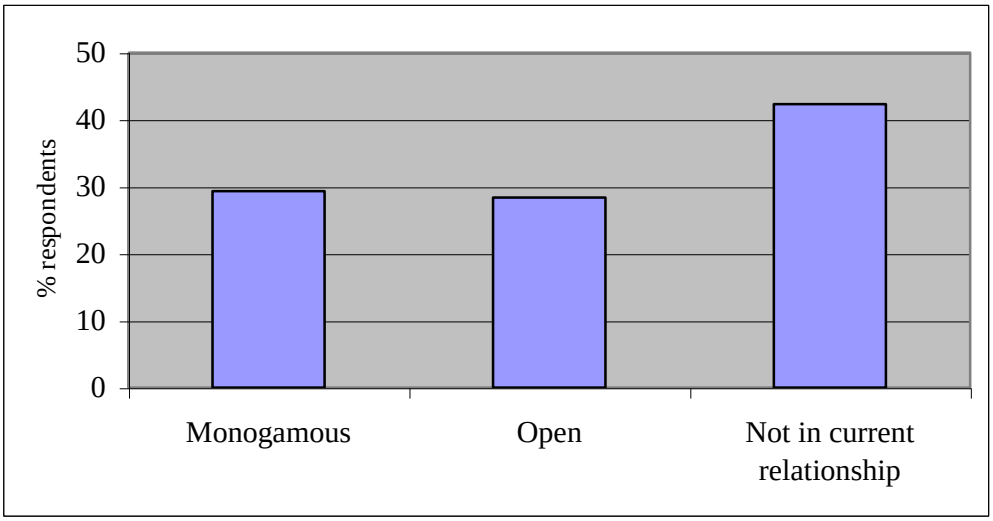


Figure 4.6: Description of current relationship (all participants)



4.3 Health Status and Access to Health Services

4.3.1 General and Mental Health Status

Participants were asked about their general and mental health status (see Figure 4.7). Eighty percent of respondents rated their general health status as 'very good' or 'excellent,' and 73% of respondents rated their mental health status as 'very good' or 'excellent.' Figure 4.8 summarizes, by age group, the percentage of respondents who self-reported their general and mental health as 'very good' or 'excellent.' The percentage of respondents who reported 'very good' or 'excellent' general health was highest among respondents aged 25 to 34 years at 81%. The percentage of respondents reporting 'very good' or 'excellent' mental health was lower in the younger age groups, trending upwards with an increase in age. Ninety-one percent of respondents aged 55 to 64 years reported 'very good' or 'excellent' mental health.

Figure 4.7: Self-reported general and mental health status

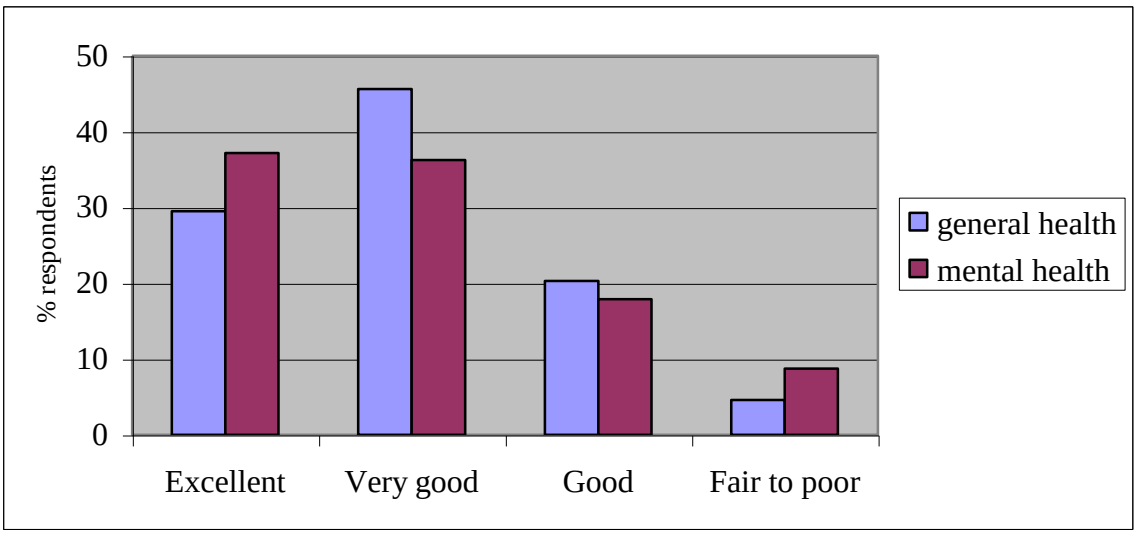
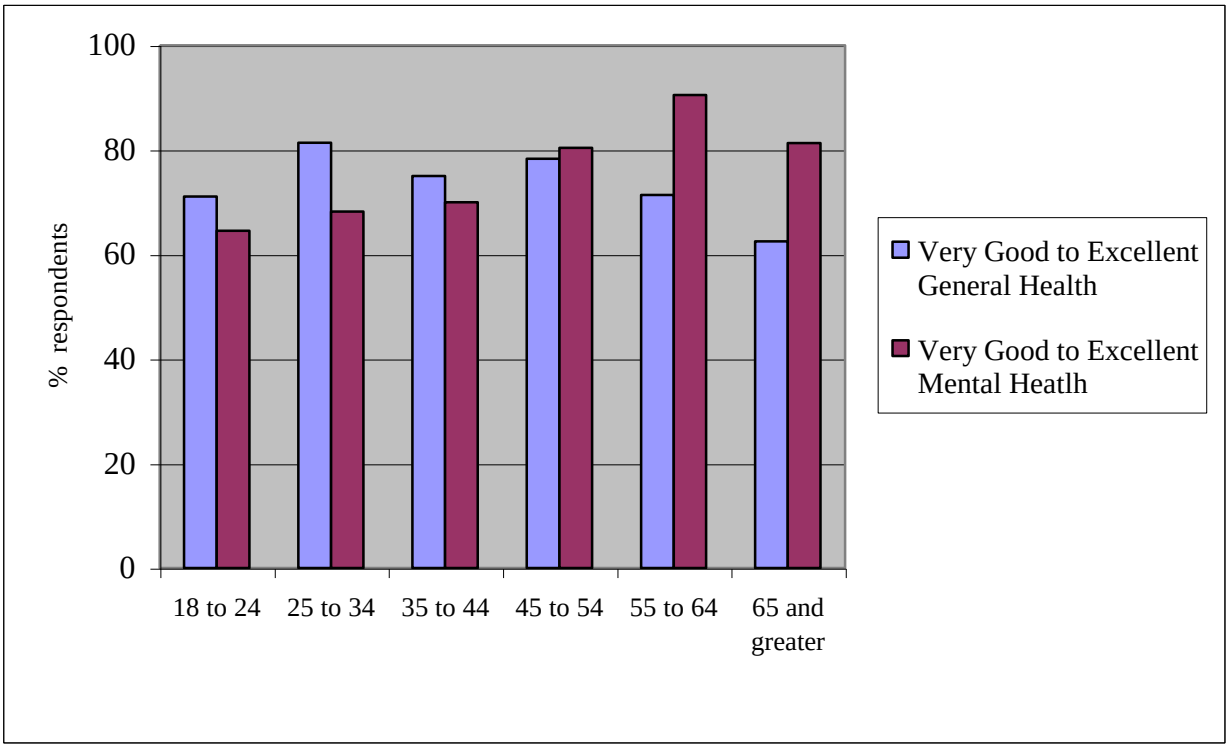


Figure 4.8: Self-reported general and mental health status, by age group



4.3.2 Stress

Overall, approximately three-quarters of respondents described most days as 'not very' or 'a bit' stressful (see Figure 4.9). A comparison of stress levels reported by age group is presented in Figure 4.10. When compared with other age groups, a slightly higher percentage of respondents aged 18 to 24 report most days as being 'very stressful.' Three-quarters of respondents 65 years of age and greater report most days as 'not very stressful,' while 25% of respondents in the youngest age group, 18 to 24 yrs, report most days as 'not very stressful.'

Figure 4.9: Self-reported stress level on most days

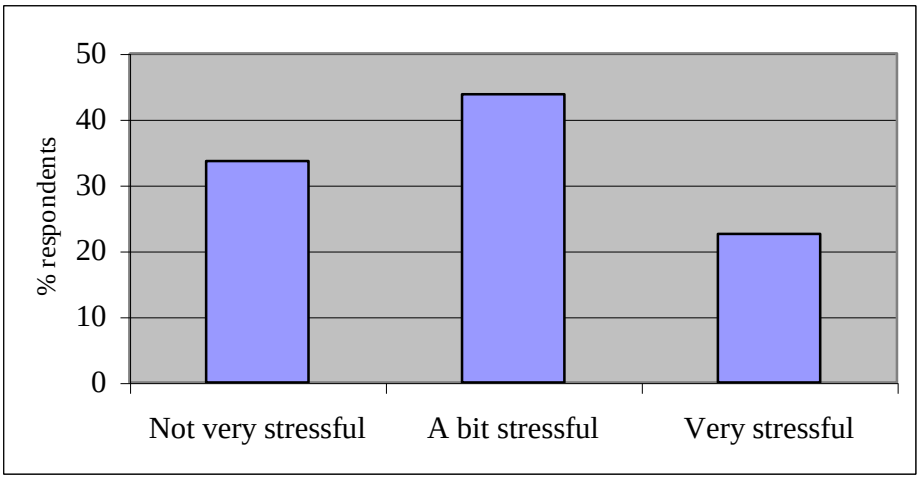
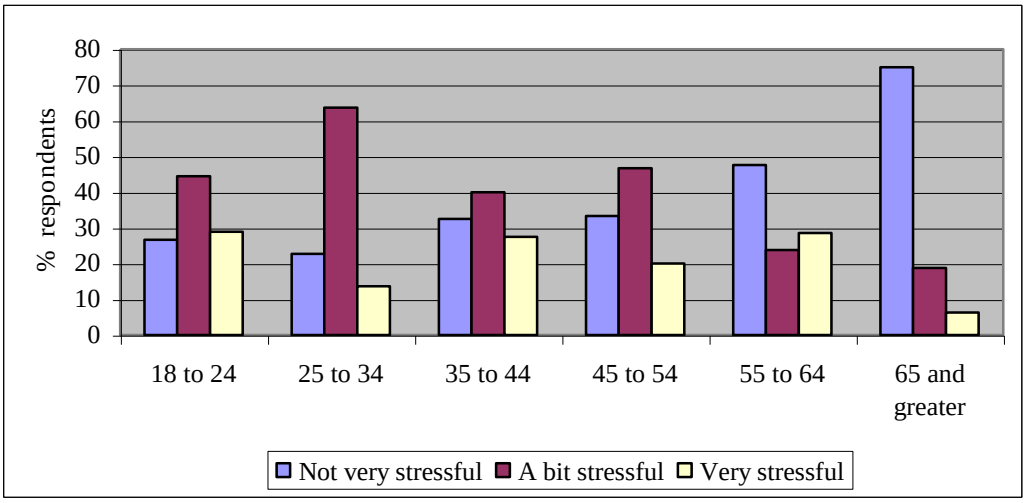


Figure 4.10: Self-reported stress level on most days, by age group



4.3.3 Utilization of health services and experiences of homophobia

Eighty-one percent of participants reported having a regular medical doctor, and a high majority of these indicated that their physician was aware of their sexual orientation. Respondents were asked about their use of a variety of health services during the past year and whether they had experienced any homophobia during their use of the services. Ninety-five percent of respondents reported using health services in the past 12 months, and 79% of respondents who used health services did not experience any homophobia.

4.4 Dried Blood Specimen (DBS) Test Results

4.4.1 Prevalence of HIV, Hepatitis C, Syphilis, and Herpes

One hundred and eighty-four respondents consented to provide blood specimens for testing HIV, hepatitis C, and syphilis. Of these respondents, 168 consented to additional testing of herpes 1 virus and herpes 2 virus, and lab-confirmable results were obtained on 136 of those samples. Results from the other 32 specimens were not conclusive.

The prevalence of HIV in the M-Track respondents who provided a DBS sample was 13.6%. Eighty-three percent of HIV positive cases occurred in respondents 35 to 54 years of age. The prevalence of hepatitis C was 2.7%, while the prevalence of syphilis was 3.1%. It should be noted that the hepatitis C and syphilis lab tests identify antibodies rather than the infectious agents themselves. Therefore, the prevalence percentages for hepatitis C and syphilis represent both the individuals who have the infections currently and the individuals who have had them in the past and may no longer be infectious.

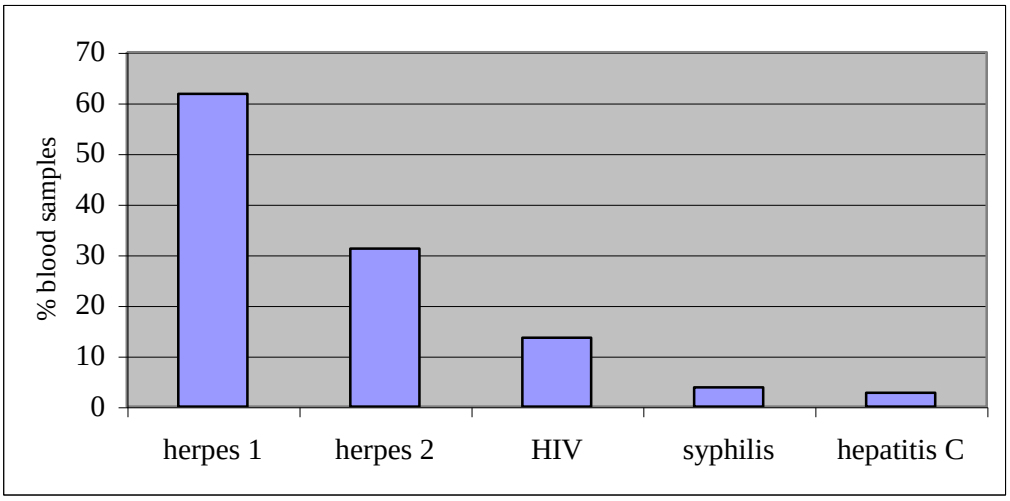
The prevalence of herpes 1 virus in the M-Track respondents who provided blood samples was 61.8%, and the prevalence of herpes 2 was 31.2%. The majority of herpes 2 cases, 58%, occurred among respondents who were 25 to 54 years of age. Herpes 1 lesions, or cold sores, commonly occur orally but may be transmitted to the genitalia. Herpes 2 lesions are typically genital but may also occur around the mouth. Therefore while some of the herpes 1 infections may have been acquired through sexual behaviour, many respondents would not be considered to have herpes 1 as a sexually transmitted infection (STI). The presence of herpes 2 is usually considered an STI even in the absence of genital lesions because the virus is primarily transmitted through sexual activity. Table 4.1 and Figure 4.11 summarize the prevalence of HIV and each STI.

Table 4.1: Estimated prevalence of HIV, hepatitis C, syphilis and herpes infection*

STI	Prevalence (%)
HIV	13.6
Hepatitis C	2.7
Syphilis	3.1
Herpes 1 (HSV1) **	61.8
Herpes 2 (HSV2) ***	31.2

* Positive tests for hepatitis C and syphilis represent current and past infections.
** number of samples = 138, *** number of samples = 136

Figure 4.11: Estimated prevalence of HIV and other STIs*



* Positive tests for hepatitis C and syphilis represent current and past infections.

4.4.2 HIV/STI Co-Infections

Twenty-five dried blood samples from M-Track participants were positive for HIV. Of these 25 samples, fewer than five were co-infected with syphilis or hepatitis C. Eighteen of the 25 HIV-positive individuals also consented to additional testing. The prevalence of herpes 1 and herpes 2 in these respondents was 88% and 83%, respectively.

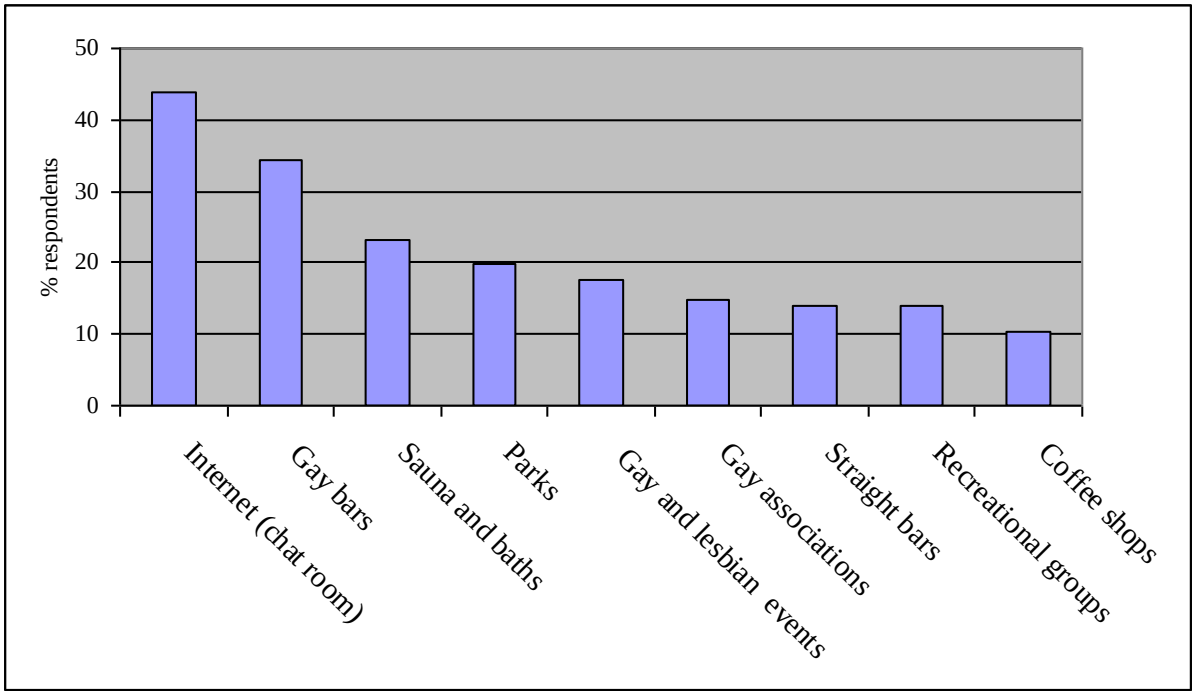
4.5 Sexual Practices and Risk Behaviours

Respondents were asked about their sexual practices and certain behaviours that can increase the risk of acquiring sexually transmitted infections. Sexual behaviour questions included those on location and frequency of looking for sex, drug use prior to sex, and sex with casual partners.

4.5.1 Places Where Respondents Looked for Sex

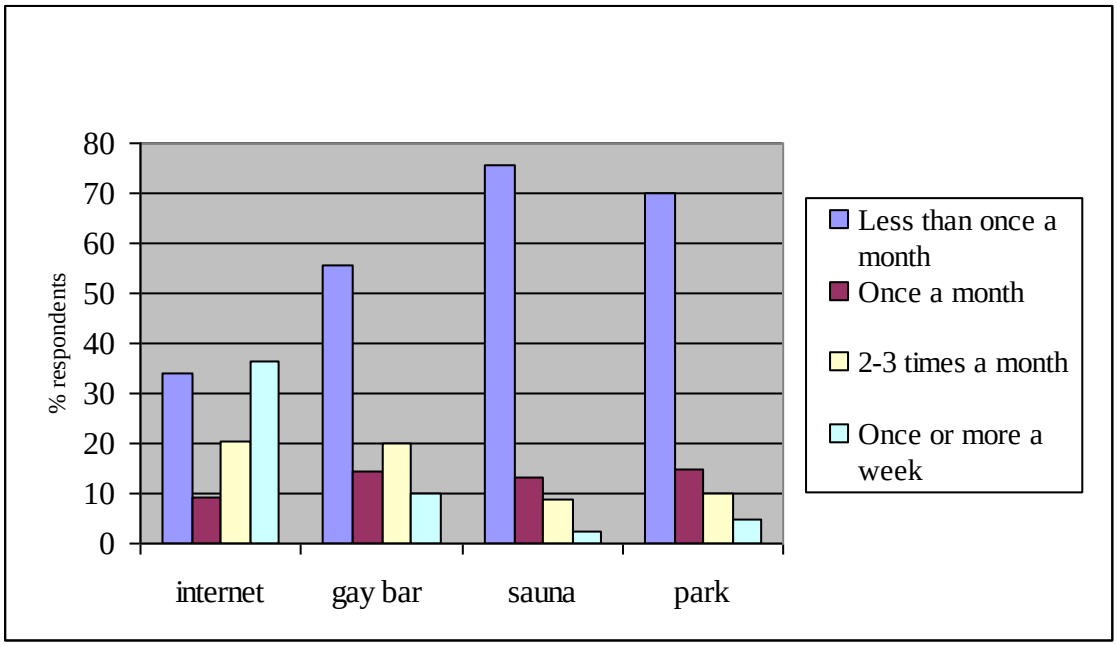
The most common public settings where respondents reported looking for sex in the past 6 months were the internet, gay bars, saunas/baths, and parks. Ten-percent or less of participants reported looking for sex in the following places: telephone chat line, personal ads, after-hours clubs, sex parties, community organizations, gym/health clubs, public restrooms, rave parties, and bicycle paths (see Figure 4.12).

Figure 4.12: Public settings where respondents report looking for sex in the past 6 months



The frequency with which M-Track respondents reported looking for sex in the most commonly reported places is summarized in Figure 4.13. Approximately one-third of respondents who looked for sex on the internet reported doing so once or more per week.

Figure 4.13: How often men look for sex in selected places



4.5.2 Drug Use and Sex Life

Use of injection and non-injection drugs can result in subsequent high-risk sexual behaviours including unprotected sex. Injection drug use among respondents was low. Cocaine was the drug most frequently injected, with approximately 11% of respondents reporting ever having injected it. However only 2% had injected cocaine in the past 6 months. Approximately 5% of all respondents reported ever having injected crystal methamphetamine.

Alcohol was the most commonly reported drug used within 2 hours of having sex. In the 6 months before the survey, approximately one-quarter of respondents used alcohol more than half the time before sex. Other drug use prior to sex was substantially lower (see Table 4.2).

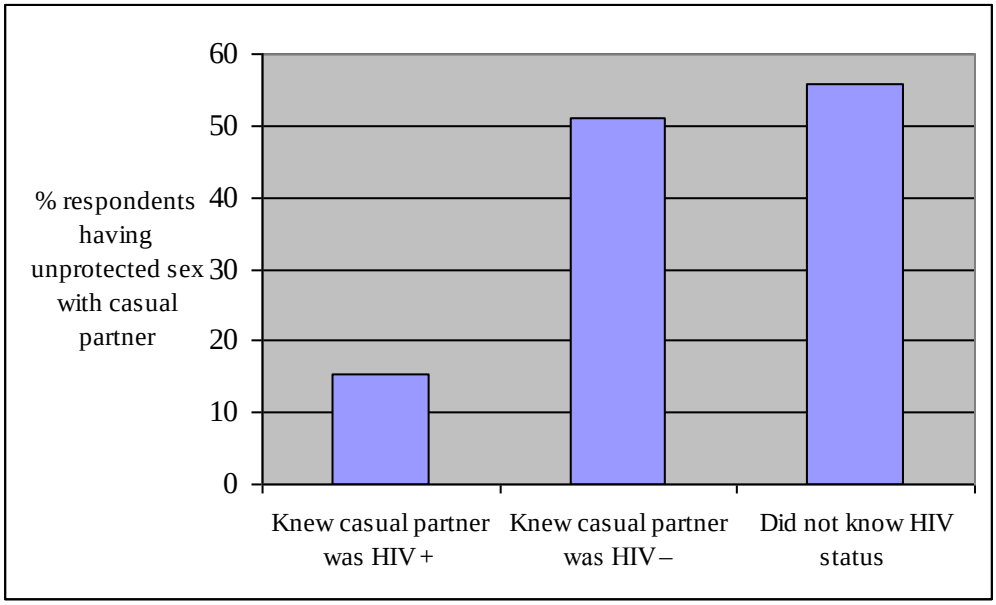
Table 4.2: Percentage of respondents reporting drug use 2 hours prior to sex

Drug	More than half the time	Less than half the time	Never
Alcohol	26.2	46.5	27.3
Marijuana/pot/hash	15.5	21.9	62.6
Poppers	6.4	16.0	77.5
Cocaine/crack/freebase	3.2	16.0	88.8
Erectile drugs	2.7	11.2	86.1
Crystal meth	0.5	4.3	95.2
Ecstasy	0	9.1	90.9

4.5.3 Sex with Casual Male Partners

Three-quarters of respondents reported having had sex with a casual male partner in the past 6 months. Forty percent of the respondents who'd had sex with casual partner(s) in the past 6 months also reported having had unprotected anal sex with at least one casual male partner during this time. More than half of these respondents were not aware of the HIV status of the casual sex partner. Figure 4.14 summarizes respondents' awareness of the HIV status of the casual partners with whom they'd had unprotected sex.

Figure 4.14: Awareness of HIV status of casual sex partner with whom respondent has had unprotected anal sex



4.5.4 Sex in Exchange for Money, Drugs, or Services

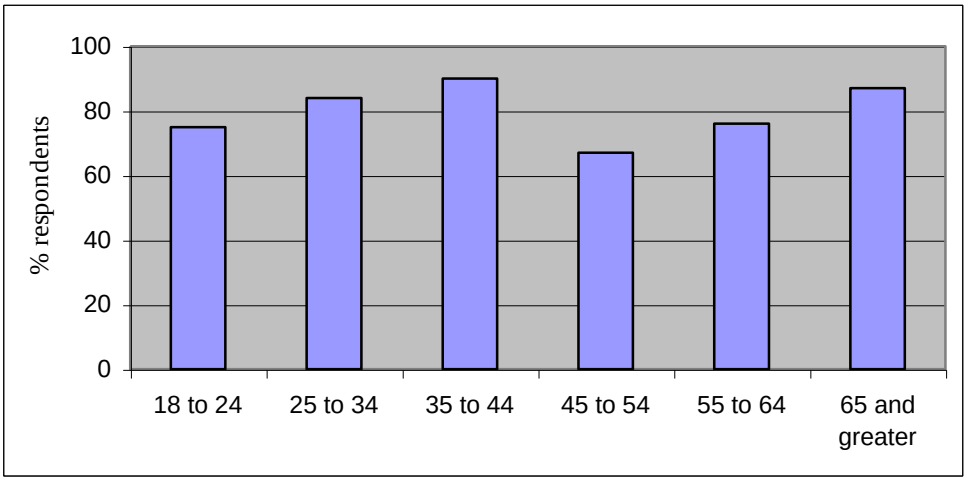
Respondents were asked whether they had ever exchanged money, goods, or services for sex. Approximately 5% of respondents reported giving money for sex, and 3% reported receiving money or drugs in exchange for sex.

4.6 Testing For HIV and Sexually Transmitted Infections

4.6.1 HIV testing

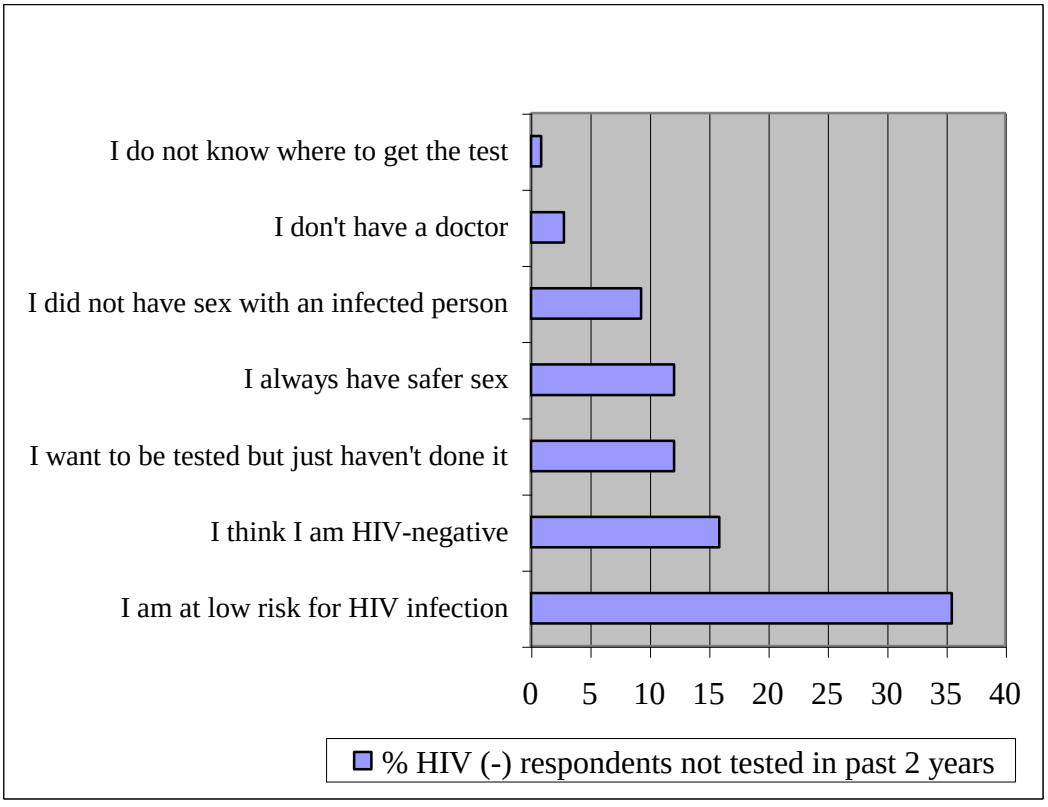
Respondents were asked for details of their previous HIV testing. Approximately 90% of respondents reported ever being tested for HIV. Seventy-four percent of these respondents had been tested at least once in the past two years. Figure 4.15 summarizes HIV testing in the past two years by age groups. Ninety percent of respondents in the 35 to 44 year age group reported testing for HIV in the past two years. Seventy-five percent of respondents in the lowest age group, 18 to 24 years, reported testing for HIV in the past two years.

Figure 4.15: HIV testing in past two years by age group



Respondents who had not been tested in the past two years and who indicated on the survey that they were HIV negative were asked about why they had not been tested recently. The most common reasons given by respondents are presented in Figure 4.16.

Figure 4.16: HIV (-) respondents' reasons for not testing in past two years



4.6.2 Awareness of HIV Status

Ninety-six percent of survey respondents who provided blood samples correctly self-reported their HIV status. Of those respondents who reported ever testing for HIV, only 1% indicated they did not receive their results.

4.6.3 Other STI Testing

Approximately two-thirds of respondents reported having been tested at least twice in the past two years for each of the following: syphilis, gonorrhea, and hepatitis C. Twenty percent of the respondents who tested positive for HIV were not tested for syphilis after their diagnosis, though this testing is generally recommended.

4.7 Hepatitis A and Hepatitis B Immunizations

Men who have sex with other men are at higher risk of acquiring hepatitis A and hepatitis B than the general population. While both are viruses, hepatitis A is transmitted through the fecal/oral route, and hepatitis B is primarily transmitted through blood and body fluids. Full protection from hepatitis A and hepatitis B is available through a series of injections. These injections are currently funded by public health for men who have sex with other men and are available at many health units.

Survey respondents were asked whether they had ever been immunized against hepatitis A and hepatitis B. These results are summarized in Figures 4.17 and 4.18. Of those who knew their immunization history, two-thirds indicated they had been vaccinated for hepatitis B. This percentage was similar across all age groups with the exception of men 65 years of age and older. Fifty percent of this age group reported receiving any hepatitis B vaccine. Approximately 50% of respondents stated they had received hepatitis A immunization. This was slightly higher in the 35 to 64 year age groups and lower in the younger and oldest age groups. Many respondents who reported being vaccinated had not received the complete vaccine series for hepatitis A or hepatitis B.

Figure 4.17: Prevalence of hepatitis A and hepatitis B vaccination (at least one injection)

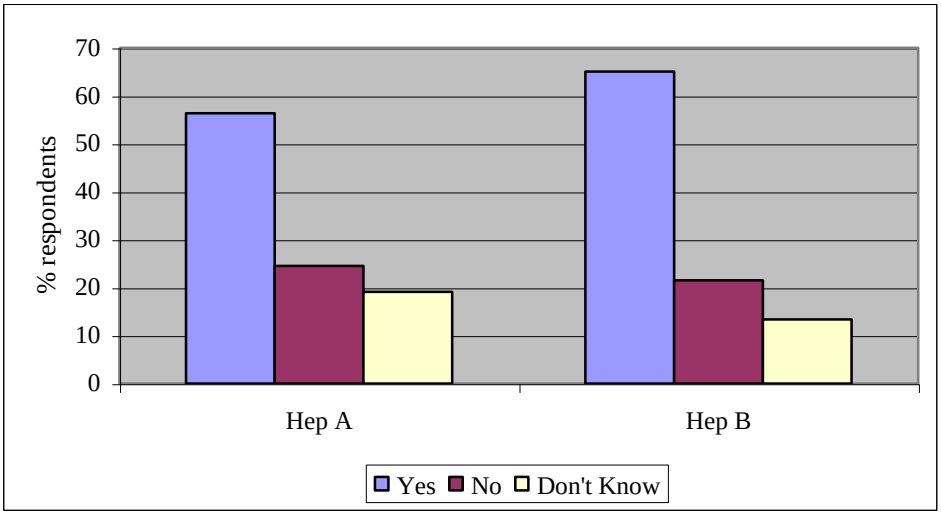
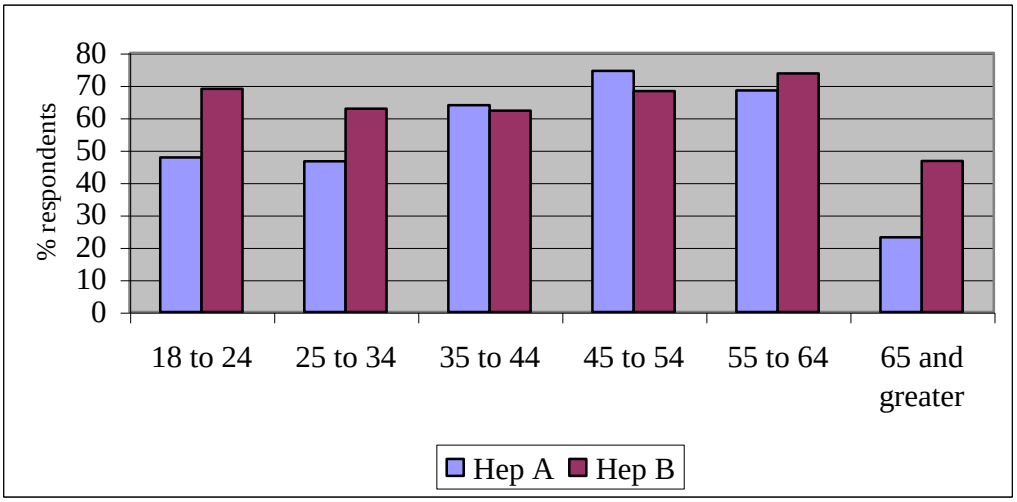


Figure 4.18: Prevalence of hepatitis A and hepatitis B vaccination, by age group (at least one injection)



4.8 Self Esteem and Social Support

Low levels of self-esteem and social support can be associated with high-risk behaviours. With regards to self-esteem, approximately 80% of all respondents reported a positive attitude and a feeling of satisfaction towards themselves. A high percentage of respondents strongly agreed with positive self-esteem statements and disagreed with negative self-esteem statements (see Figures 4.19 and 4.20).

Figure 4.19: Positive self-esteem statements

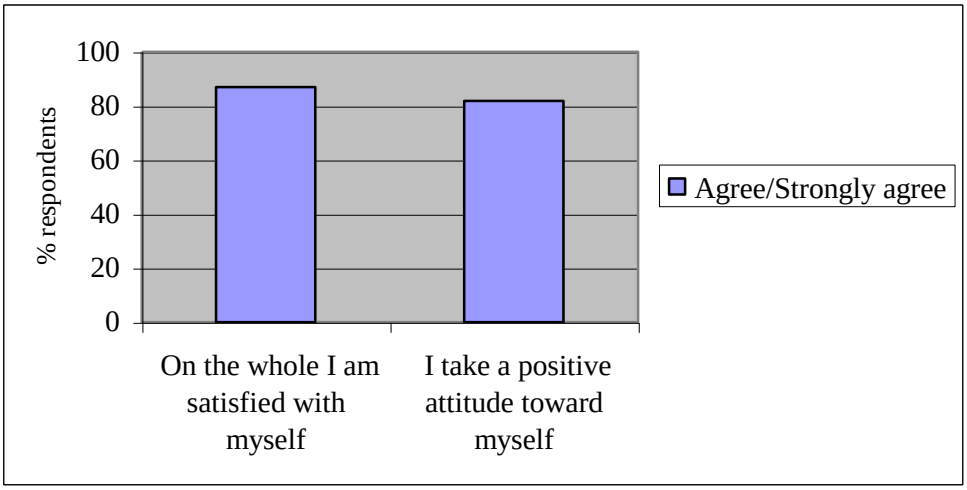
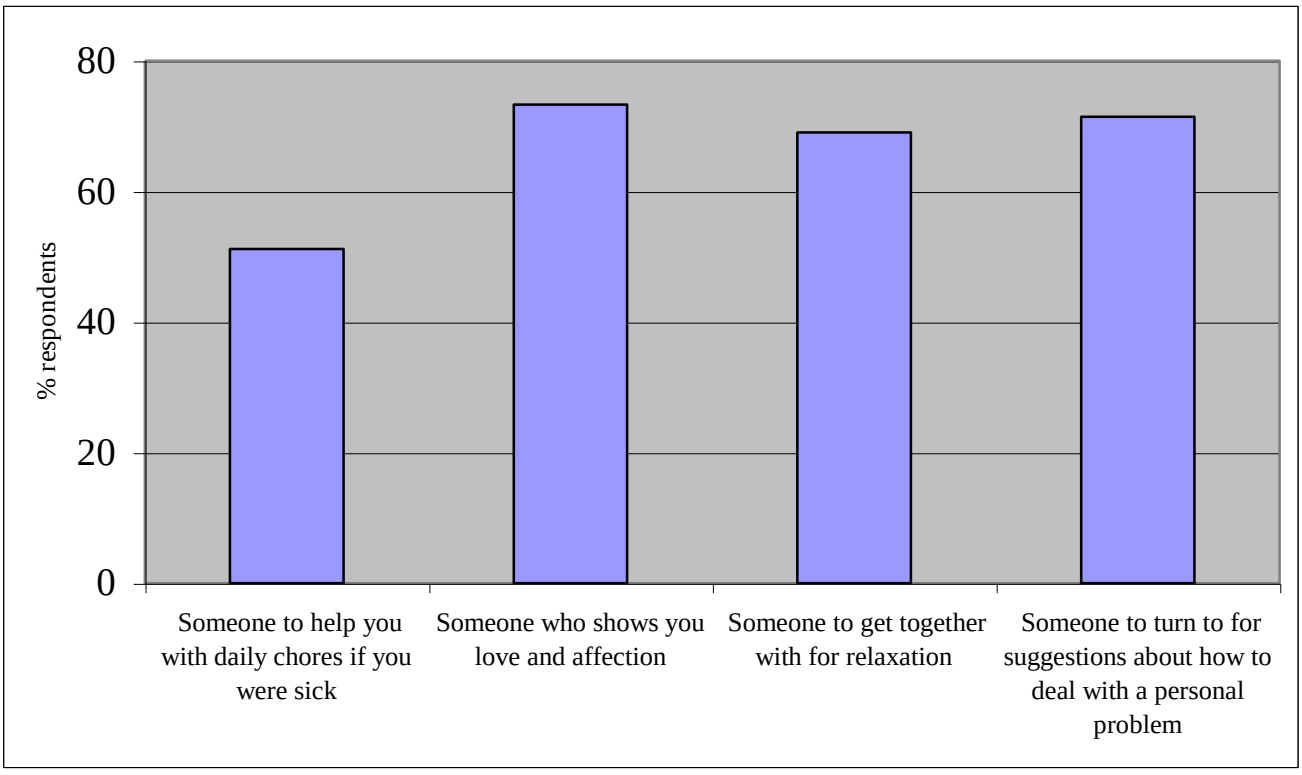


Figure 4.20: Negative self-esteem statements

With regards to social support, Figure 4.21 summarizes responses to four statements about different kinds of social support and the frequency with which they were available. Approximately 70% of respondents reported that emotional and social support were available to them most of the time, with a slightly lower percentage of respondents reporting support for daily chores if needed.

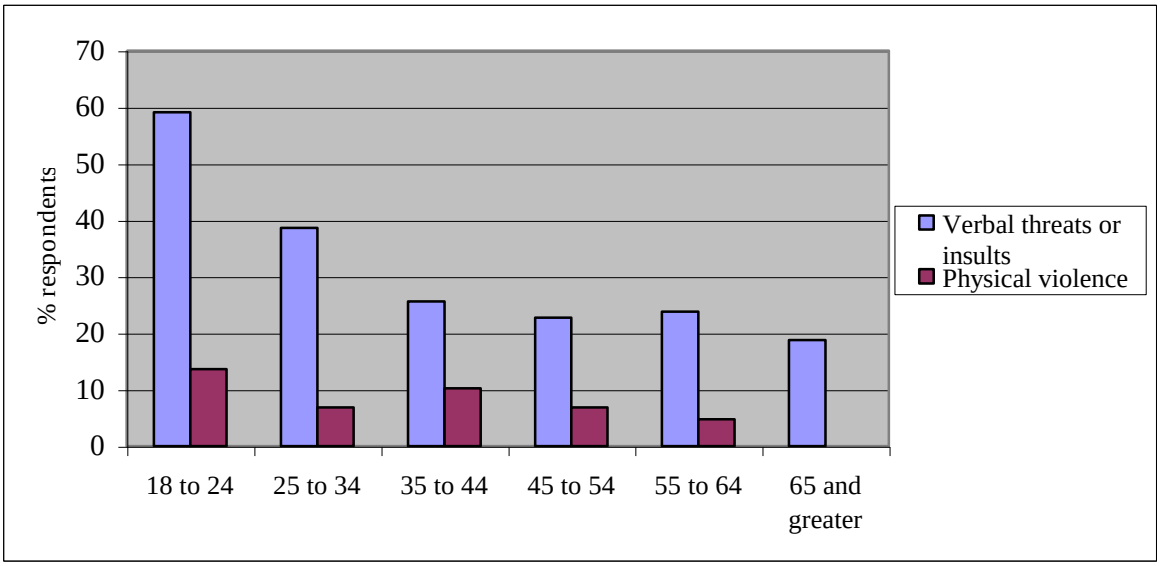
Figure 4.21: Emotional and social supports available 'most of the time'



4.9 Experiences of Prejudice or Assault

Approximately one-third of respondents experienced anti-gay verbal threats or insults in the past year, and 17% of these respondents reported the incidents to the police. Approximately 10% of respondents experienced anti-gay physical violence or assault in past year, and 44% of these respondents reported the violent incidents to police afterwards. Figure 4.22 presents these results by age group and shows younger respondents experiencing more verbal and physical abuse than older respondents. In the past year, 59.1% of the youngest age group received verbal threats or insults and 13.6% experienced physical violence.

Figure 4.22: Experience of anti-gay verbal abuse and physical assault in past year, by age group



4.10 Social Networks and Community Involvement

4.10.1 Social networks

Respondents were asked about their social networks in the gay, bisexual, and transgendered community. Approximately three-quarters of respondents indicated they knew 6 or more gay, bisexual, or transgendered (GBT) men quite well, and this was consistentacross age groups. Overall, 30% reported spending greater than 50% of their social time with the GBT men they knew quite well (see Figures 4.23 and 4.24). This percentage was slightly lower among respondents aged 35 to 54 years (25%) and highest among those aged 55 to 64 years (48%).

Figure 4.23: Number of gay, bisexual, and transgendered men whom respondents know quite well

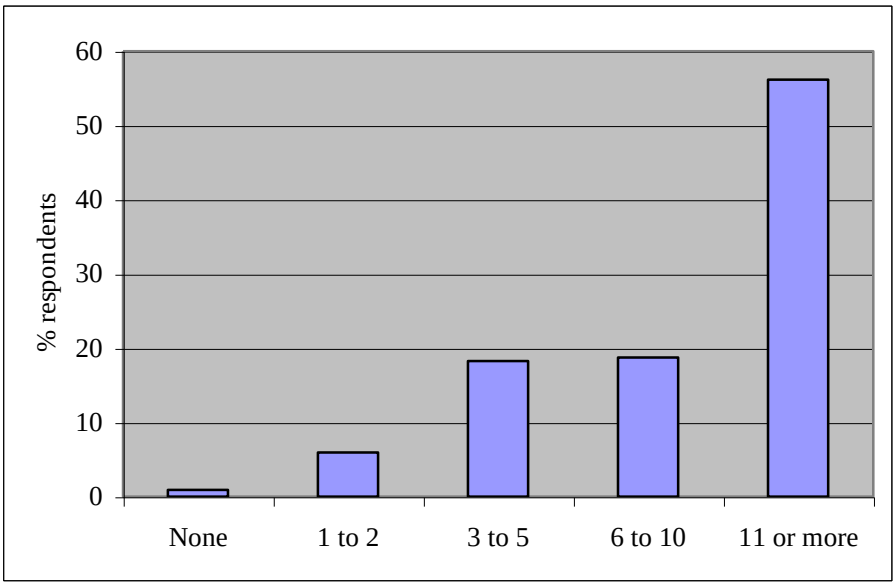
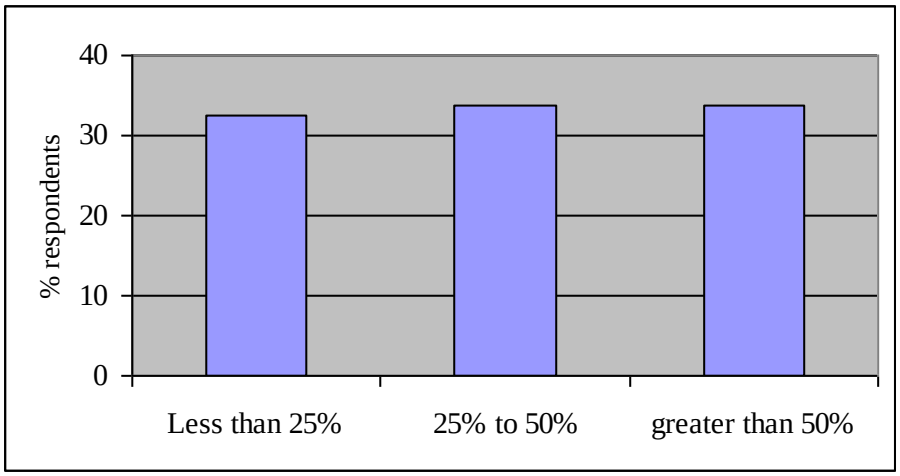


Figure 4.24: Amount of time spent with GBT men whom respondent knows quite well



4.10.2 Community Involvement

Seventy percent of all respondents surveyed felt it was somewhat or very important for them to be active in the queer community. This was slightly lower among younger respondents, aged 18 to 24 years, and higher among older respondents, aged 55 to 64 years (see Figures 4.25 and 4.26).

Figure 4.25: Importance of being active in the queer community

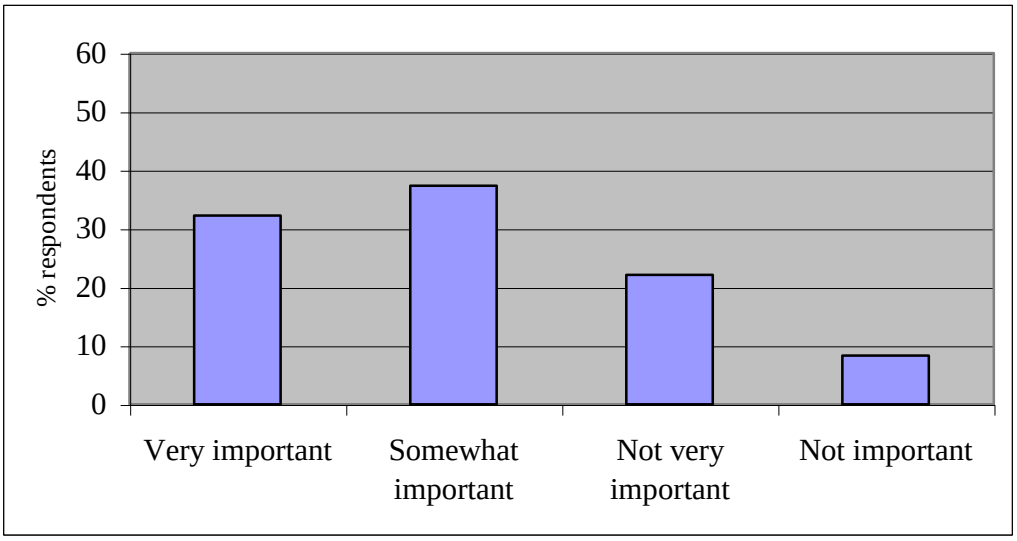
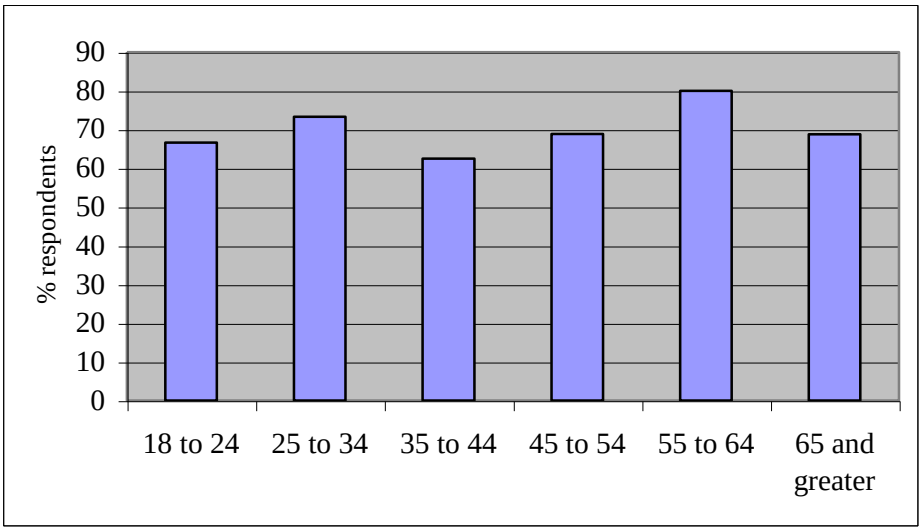


Figure 4.26: Respondents describing active community involvement as somewhat or very important, by age group



5.0 CONCLUSIONS

The M-Track survey has provided a range of information about the health of a selection of gay, bisexual, and transgendered men and other men who have sex with men in Southern Vancouver Island and the Southern Gulf Islands. The survey indicated that few respondents had been infected with hepatitis C or syphilis. However, 13.6% of respondents were infected with HIV, and over 30% were infected with herpes 2 virus, the main cause of genital herpes. Unprotected anal sex with casual partners was reported by approximately 30% of respondents. These results underscore that it is important for men to be aware of the risks of contracting infectious diseases through unprotected anal sex.

A very high percentage of survey respondents had been tested at least once for HIV, and many respondents had been tested for HIV and other STIs in the two years prior to the survey. Continuing with regular STI testing and using condoms during sex are two important ways for men to care for themselves and others in the gay, bisexual, and transgendered community.

As mentioned earlier, men who have sex with other men are at higher risk of acquiring hepatitis A and hepatitis B than the general population. Immunization coverage for gay, bisexual, and transgendered men could be improved in light of free and available publicly funded vaccines. Increased campaigning within the community could raise awareness of the need for protection against these viruses and the locations where vaccine is available.

Overall, a high percentage of men in this survey reported very good to excellent general health and mental health and reported experiencing little stress in their day-to-day lives. However, there was some variation among the age groups indicating that the younger population might experience more stress, poorer mental health, and higher incidence of anti-gay verbal and physical abuse than the older men. These issues warrant further discussion and could be addressed in future research initiatives.

Many survey respondents indicated that they were part of queer social networks, with whom they spent at least half their time. Approximately 70% of respondents reported that emotional and social support were available to them most of the time. In addition, a majority of the men in this survey felt it was important to be active in the queer community, particularly those in the older age groups.

We are grateful to the individuals who took part in M-Track for providing the information included in this report, and we hope it will be useful to the gay, bisexual, and transgendered community for the prevention of sexually transmitted infections and the promotion of men's health and wellbeing. The process of completing the M-Track survey built bridges between the health authority and the gay, bisexual, and transgendered community in southern Vancouver Island and the southern Gulf Islands. The development of these relationships will facilitate future rounds of M-Track along with other collaborations between VIHA and the community on initiatives to benefit the health of gay, bisexual, and transgendered men.

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