The Reemerging HIV/AIDS Epidemic in Men Who Have Sex With Men

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Since the first report of AIDS in 5 men who have sex with men (MSM) from Los Angeles,1 MSM have accounted for a higher proportion of AIDS cases than any other group in countries such as the United States (44%), Canada (65%), and Australia (64%).2,3 Although MSM first brought human immunodeficiency virus (HIV)/AIDS to the world’s attention and, even in the absence of external funding, were the first to promote risk reduction strategies, prevention efforts for MSM appear to have faltered.

In this article, we examine current HIV/AIDS epidemiology in MSM, discuss why the epidemic may be re-emerging, and describe what can be done to address it. Although there is recognition and reporting of MSM with HIV/AIDS from low-income and middle-income countries, including those in Africa and Asia where interventions for MSM are few, cultural stigma may be strong, and homosexuality may be illegal.5,6 This article is limited to industrialized countries and focuses particularly on the United States.

Trends in HIV/AIDS, Other Sexually Transmitted Infections, and Risk Behaviors in MSM

The number of MSM reported with HIV/AIDS is now increasing in many countries. The estimated number of US cases of HIV/AIDS among MSM by year of diagnosis in the 33 states and US dependent areas with confidential named-based HIV reporting increased from 16,167 in 2001 to 18,296 in 2005.3

In 2007, AIDS is simply not as frightening as it was before highly active antiretroviral therapy (HAART) became available. Most individuals infected with HIV can now lead reasonably healthy lives if diagnosed early and can access and adhere to treatment. Instead of a terminal illness, some have likened HIV/AIDS to a chronic, treatable condition, although outcomes beyond 10 to 12 years of treatment are unknown. Younger MSM have largely been spared the visible devastation of untreated HIV infection. Most US residents no longer view AIDS as a major health threat and person-to-person communication about the disease, an important factor in reducing risk behavior, may be decreasing.7

Whether the availability of HAART contributes to high-risk behavior is not clear. A meta-analysis of 25 studies, more...
than half of which included MSM, found no significant association between HAART use and increased rates of unprotected sex. However, unprotected sex was significantly more common in individuals who believed that HAART decreased HIV transmission. Based on preliminary data from a more recent study from the Netherlands, Bezem er et al described a 37% increase in the annual number of new HIV diagnoses among MSM since the introduction of HAART. This finding was attributed to increasing risk behavior offsetting the effect of HAART in reducing HIV transmission.

Lack of awareness of HIV infection status is a likely reason for continuing high-risk behaviors in MSM. A venue-based study of more than 5000 MSM aged 15 to 29 years in 6 US cities found that 10% of the men were infected with HIV; of these men, 77% were unaware of their infection (91% of black MSM with infection were unaware of being infected). Of men reporting that their last HIV test result was negative, 8% were found to be infected (21% of black MSM reporting a negative test result were found to be infected). Almost 60% of men who were unaware of their infection considered themselves to be at low risk for HIV infection. Infrequent testing by MSM who believe they are uninfected would also weaken the risk-reduction strategy of serosorting, in which partners who believe they have the same serostatus engage in unprotected sex.

Other factors are also likely to contribute to unsafe sexual behaviors in MSM. For example, in a longitudinal study of more than 4000 MSM in 6 US cities, substance abuse, particularly with methamphetamines and alcohol, was an independent risk factor for HIV infection. This risk presumably involves sexual disinhibition and impaired judgment in individuals under the influence of these substances.

Biomedical and Behavioral Interventions

Because many MSM are unaware of their HIV infection status, testing rates should be increased. The US Centers for Disease Control and Prevention (CDC) has recently recommended HIV screening for patients in all health care settings using an opt-out model (patients are notified that testing will be performed unless they specifically decline). For persons at increased risk for infection, such as MSM, screening is recommended at least annually.

One of the rationales supporting the CDC guidelines is that risk behavior often decreases after individuals learn of their HIV infection. In a meta-analysis of studies in which rates of high-risk sex in individuals before and after they became aware that they were infected were examined, high-risk behavior decreased after notification of a positive HIV test result. Furthermore, in a model adjusted to exclude known infected partners, the average reduction in risk behavior was approximately two-thirds.

Recent recommendations from the US Task Force on Community Prevention Services are based on strong evidence that individual-level and group-level risk reduction inter-

ventions are effective in changing sexual behaviors among MSM. However, findings from the reviewed studies may not be generalizable to all MSM, especially non-gay-identified MSM, racial and ethnic minority MSM, or substance-using MSM. How well behavioral interventions will work over time or when translated from research into practice is not known. For MSM whose risk behaviors are related to use of methamphetamines, alcohol, or other drugs, provision of appropriate substance abuse services will be needed. Mental health services will be needed for MSM whose behaviors may be influenced by mental illnesses, including depression.

Roles of other biomedical interventions to reduce HIV transmission between MSM remain uncertain. Male circumcision has been shown to reduce the infection risk in heterosexual African men by approximately 60%, but the potential role of circumcision for HIV prevention in MSM is unknown. Trials of preexposure prophylaxis, herpes simplex virus suppression, and HIV vaccines in MSM are in progress, and early studies of rectal microbicides have begun.

Leadership, Community, and Personal Action

Until the development of more effective interventions, the response to the MSM HIV/AIDS epidemic must rely more heavily on leadership (both within the MSM community and among public health officials), community mobilization, support for risk reduction, and increased emphasis on personal action. These issues, although potentially sensitive and stigmatizing, should be discussed openly and free from “political correctness.” Leadership is needed to advocate for adequate research on and implementation of effective programs and to engage credibly with communities at risk. In the 1980s, many leaders emerged within the gay community to address the need for risk reduction, despite criticisms from some of their peers that these leaders were undermining hard-won rights of sexual expression. Since then, many of these leaders have died or taken up other causes, such as HIV treatment advocacy. Although availability of treatment is critical, it is only a part of the needed response. If MSM continue to become infected, demands on treatment services will continue to increase.

In addition to re-energizing the call for safer sexual behaviors, new leaders must call for the end of stigma toward MSM, which may mitigate the internalization of homophobia leading to sexual risk behavior. This need is particularly critical within racial and ethnic minority MSM communities that bear the stigma of homosexuality along with the discrimination faced by these minorities. Political leadership is also needed to advocate for legal domestic partnerships as a way to promote stable, longer-term MSM relationships.

Community mobilization of MSM was an important feature of the early response to HIV/AIDS when the aphorism “silence equals death” captured the need for action. Many
community-based organizations were founded to address this challenge, and the need for their advocacy and health promotion activities remains critically important today. Because most HIV transmission between adults is the result of voluntary behavior, individuals can substantially influence the likelihood that they will either acquire or transmit HIV. A good example of an approach to personal responsibility is the “HIV Stops With Me” social marketing campaign, which emphasizes the role that HIV-positive individuals can take in ending the epidemic. Although this approach might be criticized for “blaming the victim,” that is not the intent; instead, it acknowledges the importance and need for personal action.

Realistic Prevention Goals

Any realistic approach to HIV prevention must acknowledge the limits of public health. Public health can only be as effective as the tools available and the collective will to use them. When a tool is highly effective and has a lasting effect, such as a vaccine, diseases can be controlled or even eradicated. When the tools require changing behaviors and maintaining behavioral changes over time, success will be much more difficult to achieve.

In an effort to increase the effect of a behavioral intervention, it may be tempting to exaggerate the danger of the condition to be avoided. However, such tactics are morally questionable and may ultimately be counterproductive. It may also be tempting to introduce legal penalties for unsafe sex; however, with the rare exception of penalties for intentional exposure to HIV, this approach is unacceptable in free societies. Although emphasizing individual and community responsibility may seem overly moralistic, establishment of community norms of safe behavior can play a key role in addressing the MSM HIV/AIDS epidemic.

Conclusions

“Silence equals death” may unfortunately be regaining relevance for some MSM. Despite advances in HIV/AIDS care, almost 6000 MSM with AIDS in the United States died in 2005, and living with HIV/AIDS is challenging. However, despite strong evidence for a re-emerging HIV/AIDS epidemic in MSM, silence on this subject is nearly pervasive.

Public health has limits and should not promise more than it can deliver. Nonetheless, advances can occur through open discussion, increased HIV testing, funding to develop and implement evidence-based public health interventions, leadership from the gay community and public health officials, and recognition of the role of personal action. Failure to address these difficult issues implies that the HIV/AIDS epidemic in MSM must be accepted as inevitable; this cannot be allowed to happen. The tragedy of the epidemic for an earlier generation of MSM must not be repeated.

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REFERENCES


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