

# Can HIV Prevention Make a Difference for Men Who Have Sex With Men?



## Have we made any progress in the gay community?

Absolutely. Men who have sex with men (MSM) were hit hard with HIV early in the epidemic, and remain the group predominantly affected by AIDS nationally. Recent publications have highlighted increased HIV infection in certain MSM populations, drawing the dangerous conclusion that prevention is not working in the gay community. Prevention does work, and many gay/bisexual men would not be alive today if it weren't for rigorous prevention efforts. In the second decade of this epidemic, it's extremely important to balance anecdotes with the weight of scientific evidence that prevention can, indeed, make a difference.

In 1990, MSM accounted for 73.2% of AIDS cases, but declined to 68.7% in 1994. Clearly, most of the decline occurred in White MSM, whose percentages declined from 51.2% to 45.5%. No such declines were observed for African-American, Asian-American, or Native-American MSM.[\(1\)](#)

While AIDS cases among certain segments of MSM have declined, another wave of infection threatens the gay community if commitment to HIV prevention should falter. We can learn a lesson from the public health experience with tuberculosis. In 1969 the federal government provided \$20 million for prevention efforts. Tuberculosis cases went down and with the decrease came further decreases in funding, until twenty years later tuberculosis cases had increased past the level from 1969. This is called a "u-shaped curve of concern", where public health improvements lead to diminished funding, which leads to increased new cases.[\(2\)](#) Funding and dedication to HIV prevention efforts must not follow a similar route.

## Why are some men still taking risks?

Just because safer sex is effective at preventing HIV, doesn't mean it's easy. Continuing safer sex behavior over a long time is difficult; we all know that it's easier to start a diet than to stay on one. For many men in the gay community, the challenge is not to start having safer sex, but to do so consistently and for the long haul.[\(3\)](#)

In the second decade of the epidemic, the gay community is struggling with the fact that AIDS is here to stay, and that the prospect of a cure is far away. Overwhelming psychological, cultural and spiritual issues surrounding living in the midst of an epidemic often overcome the ability or desire to remain uninfected.[\(4\)](#)

# Can prevention reduce new infections?

Yes. Significant and substantial reductions in HIV incidence, risk behaviors, incident AIDS cases, and surrogate markers for risk behaviors (like rectal gonorrhea) have been observed, especially among White MSM aged 30 or beyond.[\(5\)](#)

In San Francisco, CA, new HIV infections reached a high of 8,000 in 1982. In 1992, the estimated number of new HIV infections was 1,000. Comprehensive community-based HIV prevention programs targeted towards gay and bisexual men in the early to mid-1980s certainly contributed to this dramatic reduction in new HIV infections.[\(6\)](#)

Rates of rectal gonorrhea, an indicator of male-to-male transmission, have declined significantly across the US. In New York City, rates declined from 1,577 in 1982 to 50 in 1994. In Denver, CO, rates declined from 354 in 1985 to 10 in 1994.[\(5\)](#)

## What's working now?

HIV prevention programs using small group counseling, community outreach, community mobilization, stress reduction counseling, peer education, and skills training have been effective among all segments of MSM: men in epicenter cities, men in rural communities, young men, adolescents, men of color, and bisexual men.

AIDS education led by peers on a community level is effective at reaching higher-risk men. In several medium-sized towns, the most popular people in social settings were trained to deliver AIDS risk-reduction messages to their friends and acquaintances in gay bars. As a result, fewer men practiced unprotected sex.[\(7\)](#)

The STOP AIDS Project, which grew out of focus groups conducted early in the epidemic in San Francisco, CA, uses community outreach and small group counseling to reduce HIV risk. About 8,000 men are reached annually, and about 1,800 attend workshops. Self-reported rates of unprotected anal intercourse declined after the workshops, from 25.1% to 19.4%, with even greater differences among HIV positive men.

## Who is prevention missing?

Young MSM continue to be at high risk for HIV infection. In California between 1987 and 1991, HIV incidence among men born 1960-64 increased 216% in Los Angeles County and 206% in San Francisco. One study estimated that a 20-year old MSM has a 20.2% chance of seroconverting before reaching age 25.[\(8\)](#)

MSM of color in the US are disproportionately affected by the HIV epidemic.[\(9\)](#) By March 1993, Latinos comprised 17% of all diagnosed AIDS cases in the US, yet represented only 9% of the general population.[\(10\)](#) In Washington, DC, White MSM showed a 16% decrease in AIDS incidence between 1988 and 1993, while African-American MSM showed a 63% increase.[\(11\)](#)

Men who use alcohol or drugs are at a much higher risk for contracting HIV. A recent study of gay men in substance abuse treatment found alarming levels of high-risk sex, levels that approached those recorded before the AIDS epidemic.[\(12\)](#)

## What needs to be done?

Clearly, the scope of HIV among MSM calls for a national effort to reduce new infections. In Canada, the federal government sponsored a simultaneous survey of 4,803 men in 35 cities across the country. Results were published for the public, and based on this, a national intervention project for MSM is being sponsored by the Canadian AIDS Society.[\(13\)](#) The US is more than ready for a similar national effort.

Maintenance of safer practices must be encouraged and examined. Without assistance otherwise, return to unsafe practices should be expected. Service providers and scientists need to study this phenomenon and be prepared to assist those who might or have already relapsed from safer sexual practice either occasionally or altogether.

Better surveillance systems are needed. Vital and important HIV data should be much easier to find. Regular systems of surveillance that keep closer track of changes in the epidemic are needed, so that rapid responses can be mobilized in target groups where the spread of HIV is occurring.

Interventions targeted to "missed" populations are urgently needed. Although programs exist across the country, shamefully few have been evaluated for effectiveness. A comprehensive HIV prevention strategy uses multiple elements to protect as many of those at risk of HIV infection as possible. Continued funding, evaluations, and controlled trials of HIV prevention interventions for diverse groups of MSM must become a priority.[\(14\)](#)

---

## Says who?

1. Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report: US HIV and AIDS cases reported through June, 1994.
2. Reichman LB. The u-shaped curve of concern. *American Review of Respiratory Diseases*. 1991;144:741-742.
3. Stall R. How to lose the fight against AIDS among gay men: declare victory and leave the field. *British Medical Journal*. 1994;309:685-686.
4. Van Gorder, D. Building community and culture are essential to successful HIV prevention for gay and bisexual men. *AIDS & Public Policy Journal*. 1995;
5. Coates TJ, Faigle M, Koijane J, et al. Does HIV prevention work for men who have sex with men? Report prepared for the Office of Technology Assessment, Congress of the United States. February 1995.
6. Stryker J, Coates TJ, DeCarlo P, et al. Prevention of HIV infection: looking back, looking ahead. *Journal of the American Medical Association*. 1995;273:1143-1148.
7. Kelly JA, St. Lawrence JS, Stevenson LY, et al. Community AIDS/HIV risk reduction: the effects

- of endorsements by popular people in three cities. American Journal of Public Health. 1992;82:1483-1489.
8. Hoover DR, Mu-oz A, Carey V, et al. Estimating the 19878-1990 and future spread of human immunodeficiency virus type 1 in subgroups of homosexual men. American Journal of Epidemiology. 1991;134:1190-1204.
  9. Peterson JL, Coates TJ, Catania JA, et al. High-risk sexual behavior and condom use among gay and bisexual African-American men. American Journal of Public Health. 1992;82:1490-1494.
  10. Centers for Disease Control and Prevention. Update: trends in AIDS diagnosis and reporting under the expanded surveillance definition for adolescents and adults: United States, 1993. Morbidity and Mortality Weekly Report. 1994;43:826-831.
  11. Government of the District of Columbia HIV Planning Community Planning Committee & Agency for HIV/AIDS, Commission of Public Health, Department of Human Services. Comprehensive HIV prevention plan. Submitted to the Centers for Disease Control and Prevention; October 3, 1994.
  12. Canadian AIDS Society. Gaily Forward. Toronto; 1993.
  13. Proceedings from the Summit on HIVPrevention for Gay Men, Bisexuals, and Lesbians at Risk. Dallas, TX; 1994.

*Prepared by Pamela DeCarlo*

---

Reproduction of this text is encouraged; however, copies may not be sold, and the Center for AIDS Prevention Studies at the University of California San Francisco should be cited as the source of this information. For additional copies of this and other HIV Prevention Fact Sheets, please call the National AIDS Clearinghouse at 800/458-5231. Comments and questions about this Fact Sheet may be e-mailed to [FactsSheetM@psg.ucsf.edu](mailto:FactsSheetM@psg.ucsf.edu). ©1996, University of California

---

**BACK** [Return to Fact Sheets main page](#)

**HOME** [Return to CAPS home page](#)