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Centers for Disease Control and Prevention

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HIV Prevention

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Challenges Presented by the Data

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Why Does HIV Disproportionately Affect Gay Men?

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Executive Summary

HIV/AIDS is not a gay disease, but gay men are disproportionately affected by HIV/AIDS. With 1.1 million Americans currently living with HIV and 60,000 newly infected each year, HIV continues to be a major public health concern in the U.S. Gay and bisexual men and other men who have sex with men (MSM) have been particularly hard hit since the onset of the HIV crisis in the early 1980s and continue to experience disproportionate rates of HIV infection when compared to the broader population. However, the health needs of these men have been historically ignored. This is especially true during the initial years of the crisis. Despite overwhelming evidence confirming that gay and bisexual men and other MSM are most vulnerable to HIV infection, policies and prevention efforts to date have failed to adequately address the needs of this population with necessary funding and prevention services.

In March 2010, the Centers for Disease Control and Prevention (CDC) released staggering new data on the prevalence of HIV among MSM in the U.S. The data, which compared HIV prevalence among MSM with a number of national data sets on sexual behavior that estimate MSM are 2% of the adolescent and adult population, revealed that MSM are at least 44 times more likely than other men to contract HIV, and at least 40 times more likely than women to contract HIV. Further, MSM were at least 46 times more likely than other men, and at least 71 times more likely than women, to contract syphilis.

In June 2010, the CDC reported that new HIV diagnoses among MSM jumped by 17% from 2005 to 2008. MSM are the only “risk category” for which new diagnoses are increasing. For the others (heterosexual sex, injection drug users) new diagnoses are flat or declining.

MSM comprise the majority of new infections in the U.S. The CDC reports that, in 2006, gay and bisexual men comprised 53% of people newly infected with HIV. Another 4% of new infections were among gay men who also use intravenous drugs. In total, 57% of individuals newly infected with HIV in 2006, or nearly three in five, were gay and bisexual men and other MSM, even though MSM are only 2% of the adult population. This is in light of studies that report most gay men practice safer sex and are twice as likely as heterosexuals to report practicing safer sex.

The impact of HIV among MSM is even more troubling among gay and bisexual men of color. A startling 20% of new HIV diagnoses in the U.S. occur among black MSM even though black MSM represent only 0.25% of the adult population. New infections have also jumped sharply among black and Latino MSM aged 13 to 29.

The disproportionate impact of HIV on gay men is related to several social and economic factors which contribute to an increase in vulnerability to HIV infection and other sexual health issues. These factors include: poverty; homophobia; anti-gay bias; HIV stigma; substance use; incarceration; inadequate educational and employment opportunities; social isolation; and lack of community connectedness, among others.

Although gay and bisexual men from all racial and ethnic groups have consistently been the population most impacted by HIV in the U.S., resources to address HIV prevention have never been allocated to this population in the appropriate proportions. As such, efforts to stem the epidemic among gay and bisexual men have never been funded and supported at the levels needed, nor have they been sustained over time. Prevention programs that integrate behavioral and biomedical interventions, and community-level and structural interventions that prioritize gay men’s needs and address the underlying factors that help create an environment in which HIV thrives, are sorely needed—without a loss in support for HIV/AIDS care and treatment.

Despite strides in HIV treatment, AIDS continues to take the lives of many people, including MSM. The health of gay and bisexual men and
A Note on Language

Identity among gay and bisexual men can take many forms. Like heterosexual people, gay, bisexual and other men who have sex with men identify with communities based on a multitude of characteristics, including gender, race, and religion, among others. However, unlike members of other groups, most gay and bisexual men are not born into communities that support and affirm their identity in terms of sexual orientation. In fact, many are born into communities that are unsupportive or stigmatizing of same-sex attraction and gay identity. As a result, some men take years to adopt a gay or bisexual identity, while others may never adopt a gay identity yet still engage in same-sex relationships. How one chooses to identify varies from person to person.

The term “gay” first emerged in the mid-20th century to describe men who are sexually attracted to other men and is now commonly used in reference to social or cultural identity and political or legal issues. “Gay” is often preferred over the term “homosexual,” which is usually used solely to describe sexual activity within psychological or clinical contexts. Further, because homosexuality was regarded as a mental illness in the U.S. until 1973, many gay men believe the word has negative connotations and fails to highlight the love and intimacy shared in relationships between men.

Bisexuality is both an identity and a behavior used to describe emotional, sexual, and romantic attraction to men and women. Contrary to misperceptions, bisexuality is not a transitional stage between heterosexuality and homosexuality, but rather a separate sexual orientation. Though some bisexual men have both same-sex and opposite-sex relationships, others experience only one or the other.

Men who have sex with men, commonly referred to as MSM, is a term that was established in the early 1990s within the realm of HIV and AIDS research. Unlike the terms “gay” and “bisexual,” “MSM” describes a behavior rather than an identity. “MSM” can be used to describe self-identified gay and bisexual men, as well as heterosexual men who engage in sexual activity with other men, but do not consider themselves gay or bisexual. In this sense, “MSM” is the most inclusive term. However, in this paper, due to some of the concerns raised by Young and Meyer (2005) and others, and for the purpose of readability, we will often use the term “gay men” to refer to MSM regardless of how they identify. In this sense, “gay” is less about a self-identity, though it is likely that most MSM in the U.S. identify as “gay” or some synonymous term, like “same-gender loving.” Instead, “gay” is synonymous for “homosexually active.”

The U.S. Department of Education and CDC should partner with state and local health and education departments to promote comprehensive, age-appropriate sex education in schools to address the sexually transmitted infection (STI) epidemic among our nation’s youth (nearly 10 million STIs per year among 15–24 year olds).

The federal government and all 50 state governments should support gay-affirming interventions and activities in schools, such as gay-straight alliances and anti-bullying curricula.

HHS, CDC and state and local health departments should promote social acceptance of gay and bisexual men and combat anti-gay bias as a public health threat, specifically funding social marketing campaigns aimed at increasing family acceptance of gay sons.

Community-based organizations and public health departments must reach gay men with HIV prevention materials where gay men meet and socialize, making use of social networks and the Internet.

other MSM is a national concern that warrants greater attention, commitment, and allocation of resources. This report reviews the latest available HIV incidence data (newly diagnosed infections) as well as HIV prevalence data (cumulative total number of people living with HIV and AIDS) and discusses the data’s challenges and implications.

This report concludes with policy recommendations. Of the recommendations provided, Gay Men’s Health Crisis (GMHC) would like to highlight the following:
The hardest-hit populations in the U.S. are clearly young black and Latino gay and bisexual men, white gay men in their 30s and 40s, and black women, most of them heterosexual.

The HIV Epidemic among Gay and Bisexual Men and Other MSM: National Data

HIV Incidence

The number of new HIV infections in a specific population during a specific period of time is called HIV incidence. In August 2008, the CDC released the most recent estimates of HIV incidence, which revealed that the HIV epidemic is—and has been—worse than previously known. Using new laboratory tests that differentiate recent from long-standing HIV infections, the CDC found that in 2006 approximately 56,300 people age 13 years or older were newly infected with HIV in the United States, a figure considerably greater than the CDC’s previous annual estimate of 40,000. Following are some of the most salient figures from the 2006 data:

- 53% of all newly infected individuals contracted HIV from male-to-male sexual contact.
- 4% of all newly infected individuals reported engaging in both male-to-male sexual contact and intravenous drug use. Combining this figure with the 53% figure above, a full 57% of estimated new infections were among men who have sex with men.
- 73% of all newly infected individuals were men. Of these men, 72% contracted HIV through male-to-male sexual contact. By race/ethnicity, male-to-male sexual contact was responsible for 81% of new infections in white men, 63% of new infections in black men, and 72% of new infections in Latino men.  
- 45% of newly infected individuals were black, and nearly two thirds (65%) of these were men. The majority (63%) of newly diagnosed black men reported having unprotected sex with another man.
- 17% of those newly infected were Latino. Of those, 76% were male; of the Latino men, 72% reported MSM behavior.
- 35% of those newly infected were white Americans. White gay men accounted for close to half (46%) of all new HIV infections among gay or bisexual men.
- Among gay men overall, more young black men (ages 13–29) became infected with HIV than did any other age/racial group. The number of new infections among young black gay and bisexual men was roughly twice that of young white and Latino gay and bisexual men. Most new infections among white gay men occurred in those aged 30–39, followed by those aged 40–49.
- Among Latino MSM, most new infections occurred in the youngest age group (13–29), though a substantial number of new HIV infections were among those aged 30–39.

These new figures underscore the severe impact of HIV among gay and bisexual men of all races and ethnicities. Overall, the hardest-hit populations in the U.S. are clearly young black gay and bisexual men, young Latino gay and bisexual men, white gay and bisexual men in their 30s and 40s, and black women, most of them heterosexual.
448 per 100,000 people in the U.S. are living with HIV or AIDS.  
224 per 100,000 white Americans are living with HIV or AIDS. 
585 per 100,000 Hispanic Americans are living with HIV or AIDS.  
1,715 per 100,000 black Americans are living with HIV or AIDS.

Gender
- 75% of people living with HIV in the U.S. were men; 25% were women.

Age
- 70% of people living with HIV were between the ages of 25 and 49. 
- 25% of people living with HIV were age 50 and older. 
- 5% of people living with HIV were between the ages of 13 and 24.

Risk Factors
- 48% of people living with HIV reported male-to-male sexual contact. 
- 5% of people living with HIV reported male-to-male sexual contact and intravenous drug use. 

A clear majority of 53% of people living with HIV are men who have sex with men.

Gay and bisexual men, who comprise 2% of all American adults, were:
- 57% of all new HIV diagnoses in the U.S. 
- Nearly half (48%) of all people living with HIV in the U.S. 
- A clear majority (72%) of all newly infected men. 
- Nearly two-thirds of the men living with HIV/AIDS (64%).

HIV Prevalence

Based on 80% of states reporting name-based HIV diagnoses and using an extended backcalculation method, the CDC can now more accurately estimate HIV prevalence.29,30 HIV prevalence is the number of people living with HIV—with or without a diagnosis of AIDS—at a point in time.31 The CDC now estimates that roughly 1.1 million adults and adolescents were living with diagnosed or undiagnosed HIV infection in the United States at the end of 2006.32 The CDC figures break down this population by category, including the following:

Race
- Blacks comprised 12% of the total U.S. adult and adolescent population, but accounted for 46.1% of persons estimated to be living with HIV (PLWH). 
- Latinos comprised 15% of the total adult and adolescent population but accounted for 17.5% of PLWH. 
- Asian/Pacific Islanders comprised approximately 4.5% of the population and 1.4% of PLWH. 
- American Indian/Alaska Natives comprised .8% of the population and .4% of PLWH. 
- White non-Hispanics comprised 72% of the population and slightly more than one third of all people living with HIV (35% or 382,600 total persons).

The majority of people living with HIV in the United States in 2006 were nonwhite (65%).

Trends Over Recent Years and Since the Start of the Epidemic

In August 2008, when the CDC released new HIV incidence data for 2006, it also estimated retroactively that the number of annual new infections was higher than we thought going back to the early 1990s.

The CDC now estimates the HIV prevalence for 2003 was 994,000 persons, revealing that HIV prevalence in the U.S. increased by approximately 112,000 persons (11.3%) from 2003 to 2006. This increase is attributed to longer life spans for people living with HIV and AIDS. More people are becoming infected than are passing away from the disease. The rates of new

What percentage of the adult population is men who have sex with men?

How one measures homosexuality and bisexuality affects what percentage of the population is viewed as gay or bisexual. If one measures attraction, one gets the highest rates. If one measures sexual behavior one gets lower rates, and if one asks about self-identification one gets the lowest rates.

In March of 2010, the CDC released data estimating the population size of gay and bisexual men in the U.S.—defined as the proportion of men who reported engaging in same-sex behavior within the last 5 years.33 Analyzing nationally representative surveys,34 the CDC estimated that MSM comprise 2% of the overall U.S. population aged 13 and older.35
infection during these years held steady.

As the number of people living with HIV increases, there are more opportunities for transmission. Yet HIV transmission rates have not increased. Specific prevention efforts, and the lowering of HIV viral load to undetectable levels in individuals with access and adherence to treatments, help to hold down new infections.

However, transmissions have been increasing among gay and bisexual men since the early 1990s. The Journal of the American Medical Association published a detailed review of the new incidence figures, with illustrations depicting that infections from male-to-male sexual contact, which had peaked in the mid 1980s and dropped significantly in the late 1980s, have been rising steadily since the early 1990s (see chart, below). Since the late 1990s, male-to-male sexual contact is the only behavioral transmission category in which numbers have continued to rise. Decreases in diagnoses were observed in all risk transmission categories except this one.

**Related Statistics**

**Unknown HIV Serostatus**

Through its National HIV Behavioral Surveillance System, the CDC found that 25% of the gay and bisexual men surveyed in five large U.S. cities were infected with HIV, and that 48% of those infected were unaware of their status.

In a 2005 study of young gay and bisexual men, 77% of those who tested HIV-positive mistakenly believed that they were not infected. Young black gay men in this study were more likely to be unaware of their infection—approximately 9 of 10 young black gay men compared with 6 of 10 young white gay men. Of the men who tested HIV-positive, most (74%) had previously tested negative for HIV, and 59% believed that they were at low or very low risk.

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![Diagram showing estimated new HIV infections by transmission category.](image)

Tick marks denote the beginning and end of a year. The model specified periods within which the number of HIV infections was assumed to be approximately constant.
Challenges Presented by the Data

The national data on new HIV diagnoses for 2006 reflect key challenges in preventing HIV transmission among gay men and other men who have sex with men. Particular challenges are discussed by race/ethnicity and age.

Race/Ethnicity

Young gay men who identify as black or Latino under the age of 30 and white men over the age of 30 are all experiencing increasing HIV incidence. However, black gay men are at greatest relative risk for HIV, followed by Latino gay men. We cannot effectively address the strikingly disproportionate rates of infection until we better understand the factors placing each group at risk; only then can we craft culturally appropriate and effective HIV prevention approaches.

In a meta-analysis of several studies to explain the high rates of HIV infection among black men who have sex with men,\(^2\) Gregorio Millett and colleagues found several contributing factors, including:

- the occurrence of STIs that may facilitate the acquisition and transmission of HIV;
- high rates of unprotected anal intercourse early in the epidemic that may have increased the background prevalence of HIV;
- lower levels of infected black MSM on antiretroviral therapy that would reduce viral load; and
- disproportionately high rates of undiagnosed HIV infection.

Millett et al. concluded that “the HIV/AIDS epidemic among black MSM is more complex and multifactorial than individual risk behavior.”\(^4\)

Other data suggest a greater range of possible factors, including lack of comprehensive sex education, family rejection due to homosexuality, stigma, lack of access to effective HIV prevention services, underestimation of personal risk, not having personally experienced the severity of the early AIDS epidemic, and partnering with older black men among whom HIV prevalence is high.\(^4\) This report will discuss a number of these possible factors in more detail. But the incidence figures highlight the need for further research that examines the causes and correlates of these racial and ethnic differences.

HIV prevention efforts have historically tended to direct attention and funding toward specific groups within the epidemic, as recognition of the disproportionate impact on them is demonstrated. This results in a periodic switch in the priority focus to the group that appears to be most at risk at the moment. While this approach may be productive, switching focus is often done at the expense of preceding work with other affected groups. This may be the case today: white gay men in their 30s and 40s were a focus of prevention efforts in the past, but they have received less attention in recent years as the need to address HIV prevention among gay men of color has become an important priority.

However, rather than scaling back resources and funding to groups that were previously seen as most affected, efforts must be sustained and increased as new needs and priorities emerge. The pie must be made bigger. The current data present an opportunity to avoid repeating past errors, broaden the focus, expand the pie, and direct energies and resources to the new trends, while at the same time continuing to support and increase the valuable work that is currently being done with black and Latino MSM. In other words, the data give us an opportunity to expand our focus, and not just focus on black and Latino men under 30, but also to reinvigorate efforts with white men who are over the age of 30.

Age

Among black and Latino gay men the bulk of new HIV diagnoses are among men in their teens and 20s; among white MSM, the bulk of new infections are occurring among men in their 30s and 40s.

The data suggest a need to conduct more research on black men ages 30 and younger. The data are particularly concerning because it is unclear what percentage of those 30 years old and younger are in the under-18 age
“The HIV/AIDS epidemic among black MSM is more complex and multifactorial than individual risk behavior.” – Greg Millett et al., 2007

range. From our experiences working with this group, younger men appear to be at particular risk; however, there are unique challenges to working with those under 18, such as the need for parental consent and other ethical considerations. The current information presents an opportunity to expand our understanding of this group by gathering more information about different developmental age cohorts, e.g., 13–18, 18–21, and 22–29, to understand which youth are most at risk, and how best to reach them.

The alarming number of new infections among young black and Latino MSM underscores the need to ensure that each new generation has the knowledge and skills to prevent HIV infection at an early age while they are beginning to learn about sex. One important way to achieve this is through consistent and reliable comprehensive sex education that is relevant to homosexually active young men, in junior, middle, and high school. According to the National Youth Risk Behavior Survey data, almost half (47%) of high school students in the United States report being sexually active. Therefore it is imperative that we provide each public school student with comprehensive sex education and science-based information on HIV/AIDS and STI prevention. It may also be beneficial to create cross-generational mentoring initiatives, to encourage older gay men and other MSM to share their knowledge, skills, and experience dealing with issues related to HIV with younger men.

The data also suggest that we must stop assuming that men between the ages of 30 and 49, especially white men, no longer need HIV testing and prevention programs; instead, we must focus on programs that promote HIV prevention at all stages of life. Given that a range of factors likely contribute to continued transmission in this age group (including homophobia, substance abuse, higher HIV prevalence within this group, mental health issues associated with aging and self-esteem, social isolation, and the difficulty of consistently maintaining safer behaviors for decades), our efforts must go beyond HIV testing to address these contributing factors.

Finally, nearly one in five new infections in the U.S. occurs among people over 50. Prevention targeting older gay men is critically needed.
Why Does HIV Disproportionately Affect Gay Men?

The 2006 data are unequivocal in showing that gay and bisexual men and other MSM become infected with HIV at much higher rates than any other group in the United States, and that the risk is greatest for gay men who are black. Several factors play a role in the disproportionate impact of HIV on MSM, including the risk of HIV infection through unprotected receptive anal sex, which is a much greater risk than other forms of transmission (such as unprotected vaginal sex), and limited access to adequate prevention services, among others. To develop appropriate and effective prevention approaches, we review some of the most important issues at play in the lives of gay men that place them at higher risk for HIV infection.

Sexual Identity and Behavior

The CDC reports growing recognition that combinations of individual, sociocultural, and biomedical factors affect HIV risk behavior among gay and bisexual men. These factors—which may include substance use, depression, childhood sexual abuse, and partner violence—have been shown to increase the practice of risky sexual behaviors. Research shows that there are higher rates of substance use and significant mental and physical health disparities among LGBT people, including gay and bisexual men. The combined effects of these problems may be greater than their individual effects. In addition, substantial epidemiological evidence indicates that gay men suffer from higher prevalence rates of a cluster of infectious and noninfectious diseases than do heterosexual men. However, there is relatively little in the way of theory to explain the emergence of these epidemics.

Ron Stall has proposed a “syndemic” theory to explain this phenomenon among urban gay men, arguing that the socialization experiences of young men reared in an environment in which homosexuality is deeply stigmatized produce men who are more susceptible to depression, substance use, violence, and HIV/STI infections in adulthood. Stall’s syndemic theory holds that the variables of social isolation, internalized homophobia, self-censoring, and gay socialization predict increased vulnerability to a wide set of psychosocial conditions in adulthood. These various epidemics interact to increase susceptibility to HIV infection, and as such, are a classic case of a syndemic phenomenon. Because it shows how social and cultural processes result in the production of poor health at the level of individuals and communities, syndemic theory holds relevance for other marginalized communities.

In the following sections we examine how different populations make sense of their cultural and sexual identities, and how this interacts with behavior. We start from the premise that culture is constantly changing and evolving and that the relationship between individuals and their culture is dynamic. As individuals are influenced by their culture, they in turn create changes in that culture. In addition, identities are multiple and intersectional. For example, individuals may identify simultaneously as gay men, black, and HIV-positive. In such cases, each category of identification represents a unique culture with its own norms, values, and beliefs.

Sexual Identity and Behavior among Black MSM

Research into HIV risk in correlation with sexual identity and sexual behaviors has yielded valuable insight into HIV among black MSM. It has also raised many questions, because there is a discrepancy between sexual behavior and sexual identity, as behavioral risk factors for HIV do not explain elevated HIV rates in this population of gay men.

A 1995 study on the differences between bisexual and exclusively homosexual men found that the prevalence of bisexuality is higher among black and Latino men than white men. Other studies show that black men are less likely than white men to identify as gay, involve themselves in gay organizations, or to read gay-related media. Men who have sex with men who self-identified as straight were more likely to belong to minority racial or ethnic groups, and they were also more likely to be married. Black and Latino men have also been found to be less likely to disclose their same-sex behaviors, particularly to female sexual partners or social contacts.
A recent literature review of bisexuality in black and Latino men found possible explanations for the discrepancy between identity, behavior, and self-disclosure. It suggests that ethnic minority men may find it hard to identify with gay culture in the United States because they view it as white, and sometimes also as a “feminine” phenomenon. That ethnic minority men report experiencing racism in the gay community only adds to this perception. Another explanation may be a fear that in order to identify as gay, one may need to play down or give up one’s ethnic background, including the social support that comes from one’s ethnic community. Many homosexually active people of color may see their ethnic community and being part of the gay community as incompatible.

These findings are important because other studies have reported that MSM who do not either identify or disclose as gay tend to have fewer sex partners than those who do. Since black MSM are less likely than white men to identify as gay or to disclose their sexual behavior, it is possible that they also have fewer sex partners. Several studies, in fact, indicate that black MSM have fewer sexual partners than white MSM. However, HIV infection rates remain higher among black MSM than white MSM.

In fact, research suggests that STIs, including HIV, remain more prevalent among black MSM than white MSM despite the fact that black MSM have comparable rates of unprotected anal sex and fewer sexual partners. Black MSM appear to be much less likely to engage in substance use, irrespective of drug type, and are significantly less likely to report using any drugs in association with HIV risk behavior.

A 2007 study suggests several factors that may contribute to high HIV infection. First, the occurrence of STIs facilitates acquisition and transmission of HIV. Black MSM in the study were more likely than white MSM to be diagnosed with a current STI and to have (or have had) gonorrhea and syphilis. A second suggested factor is the high rate of unprotected anal intercourse among black MSM early on in the HIV/AIDS epidemic. Black MSM tend to have sex with other black partners. Therefore, greater rates of unprotected anal intercourse would have increased the background prevalence of HIV among black MSM. Third, the study found that HIV positive black MSM were less likely than HIV-positive white men to be taking antiretroviral therapy (ART). ART use decreases viral load and therefore lowers HIV infectivity.

Dealing with the disproportionate impact of HIV among black MSM requires confronting both social and behavioral aspects of the high incidence. Also, understanding the discrepancy between sexual behavior and sexual identity is extremely important: in the case of black MSM, it is clearly problematic to use reported sexual identity to assess risk. The research underscores the complexity of HIV risk in black MSM and highlights the need for multifaceted approaches to dealing with HIV/AIDS in this population.

Sexual Identity and Behavior among Latino MSM

Although Latinos and Hispanics are classified as one ethnic group in the U.S., the Latino population in the U.S. is comprised of people with origins in 26 nations with significant differences in understandings of race, ethnicity, language, economic resources, educational systems, status structures, and customs. Themes that seem to cut across Latino cultures, however, are the taboos associated with homosexuality, bisexuality, extramarital affairs, and intravenous drug use.

In studies that presented factors related to substance use among Latinos that may have a direct impact on HIV transmission among gay male Latinos, Rothemberg and Spector identified the following traditional health beliefs.
that can significantly impact some Latinos’ decision to engage and continue in HIV care and mental health treatment: (1) some illness has its roots in physical and spiritual imbalances; (2) illnesses are often a sign of weakness, punishment for misdeeds or sinful acts, and a source of shame; (3) traditional healers should be sought out before, during, and/or after consultation with Western medical professionals; and (4) individuals should seek “quick-fix” injections or pills to resolve illnesses. This “quick fix” belief may be connected with the motivations of Latino gay men to use stimulants; in a study of 300 Latino gay men who used stimulants in the previous 6 months, motives for stimulant use included the desire for energy, sexual enhancement, social connection, coping with stress, and work productivity.71

Diaz and Ayala72 demonstrated the relationship between homophobia, racism and financial hardship on the one hand, and increased risk of HIV transmission among Latino gay and bisexual men in three U.S. cities (Miami, Los Angeles and New York) on the other. Their findings challenged the individual deficit-based model for understanding, which assumes Latinos are at elevated HIV risk due to low levels of knowledge about HIV, misguided assessments of risk, low perceptions of vulnerability, or lack of motivation or intention. They found that experiences of social discrimination on the basis of race, class, and sexual orientation were frequent and widespread among Latino gay men, and that “high-risk” men reported more experiences of homophobia, racism, and poverty than their “low-risk” counterparts. These findings support the need to conceptualize “health risk” as a characteristic of socially defined contexts. Using this perspective, HIV prevention programs can address those contexts and respond with efforts that result in health and well-being rather than risk and disease. This is a useful framework to consider in relation to HIV prevention efforts for all gay male populations.

Preventing the spread of HIV among Latino and black gay men and other MSM in the communities in which they live means raising uncomfortable and sensitive issues of sexual identity, homosexual and bisexual behavior, and substance use, which are difficult to talk about in any context.73 In many communities of color, homophobia and discomfort about issues of sexuality have created obstacles to efforts to promote safer sex practices.74,75 It is important to

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**Estimated number* of new HIV infections in men who have sex with men, by race/ethnicity and age group, United States, 2006**

![Estimated number of new HIV infections chart](chart.png)

* Incidence estimates are adjusted for reporting delays and reclassification of cases reported without a known risk factor for human immunodeficiency virus (HIV) but not for underreporting

† Non-Hispanic whites and non-Hispanic blacks are referred to as white and black, respectively. Persons of Hispanic ethnicity might be of any race

Note: The * †* bars denote the data range for each confidence interval

Source: CDC Fact Sheet, HIV and AIDS among Gay and Bisexual Men, 2010
introduce and maintain dialogues about sexuality, homophobia, stigma, and drug use within gay male communities of all racial backgrounds, with full awareness and sensitivity to the multiple and unique issues surrounding these discussions for each cultural group and individual.

**Sexual Identity and Behavior among Male-to-Female Transgender Persons**

A subgroup of MSM, at least according to the way the CDC currently tracks HIV diagnoses, is male-to-female (MTF) transgender persons. The word “transgender” is an umbrella term used to describe persons whose gender identity, expression, or behavior does not conform to societal gender norms associated with their sex at birth.79 Some MTF opt to alter their bodies to match their gender through cosmetic surgeries, hormone treatments, or sex re-assignment surgery.77 However, many MTF do not engage in a physical transition, but rather express their gender identity through a range of gender non-conforming behavior.78

There is currently no mechanism in place to collect information regarding the health of transgender individuals. Thus, national data on transgender women and HIV are not available. However, independent studies reveal staggering rates of HIV within the MTF population,79 higher than that of other MSM groups, including MSM injection drug users.80 Studies on transgender women report HIV positivity rates ranging from 19% to 47%.81 A recent meta-analysis of four studies estimated a national HIV prevalence of 27.7% among MTF.82 Given that the actual population size of MTF is unknown, it is likely that HIV rates among MTF may be higher than reported.

Conversely, studies on female-to-male (FTM) transgender men show substantially lower rates of HIV infection when compared to transgender women. A San Francisco study found that while 35% of transgender women were HIV-positive, only 2% of transgender men were HIV-positive.83 However, limited studies on transgender men who have sex with men indicate that they may be at increased risk for HIV and other sexually transmitted infections when engaging in unprotected sex with non-transgender men.84, 85, 86 Sexual behavior and practices vary among populations of transgender women and transgender men and warrant further investigation.

Similar to racial disparities found in general MSM populations, transgender women of color are also more adversely affected by HIV. Black MTF show the highest rate of HIV infection, ranging from 41% to 63%,87, 88 followed closely by Latina MTF, with HIV rates ranging from 23% to 29%.89 Asian and Pacific Islander MTF show lower rates of HIV infection, ranging from 4% to 27%.90 However, data may not be conclusive as many studies on transgender people have not translated their instruments into Asian languages, which may inadvertently exclude immigrant and undocumented Asian and Pacific Islanders who may be at high risk.91

Several factors place transgender women at elevated risk for contracting HIV. Melendez and Pinto (2007) describe a need among female transgender individuals to feel safe and loved by a male companion, which can lead to risky behavior and elevated risk of HIV acquisition. Pervasive discrimination and stigma also correlate with high risk behavior and negative health outcomes, including lower self-efficacy and self-esteem,92 higher rates of depression, suicidality, and self-mutilation.93, 94

Discrimination also serves as a barrier for transgender and gender non-conforming people to obtain employment.95 Limited options for earning a steady wage push transgender people to the margins of the formal economy and force many transgender people to turn to “survival crimes,” such as sex work, as a viable source of income.96 Engagement in sex work puts transgender women at greater risk of HIV due to increased exposure to violence, sexual assault, and time spent in a correctional facility.97
Gay men over 40 who are single and struggling with social isolation may put themselves at risk for HIV.

Gay and bisexual youth tend to label their sexual attractions around the same time that sexual attraction becomes most salient to heterosexual youth.\textsuperscript{104} There is no significant difference between ethnic groups in this regard. There are also no significant differences among ethnic/racial groups regarding rates of sexual identity, current sexual orientation and recent sexual activity.\textsuperscript{105} Youth tend to make initial disclosure of sexual identity to close friends at young ages that are similar across race or ethnicity, but differences arise regarding disclosure to family.\textsuperscript{106} Black youth tend to disclose to fewer people and disclose to their families later than their white peers. Further, black, Latino, and white youth were found to reach out to the lesbian, gay, and bisexual (LGB) community at similar ages.\textsuperscript{107} This reality exemplifies a need for LGB affirmative health education, prevention, and services to young adults as they are coming into their sexual identities.

Despite being first connected to the LGB community at similar ages, black youth were involved in fewer gay-related social and recreational activities than were white youth. One study speculated that after initial involvement in social activities in the LGB community, black youth retreat because of racism.\textsuperscript{108} Further, black youth were found to be more uncomfortable with others knowing about their homosexuality, and had disclosed to fewer numbers of other individuals, than had their white peers.\textsuperscript{109} However, another study found that after a 12-month assessment, black youth were more certain of their LGB identity as compared to their white counterparts.\textsuperscript{110} It appears that for black youth who experience cultural pressures against homosexuality, the confidence and strength required to accept an LGB identity will ensure a strong commitment to that identity.

Latino youth reported similar levels of comfort with others knowing about their homosexuality as did white non-Hispanic youth. However, like black youth, Latino youth had disclosed to fewer individuals than had white youth. Latino youth appear to be more comfortable with their families knowing about their sexual orientation but may not disclose their status to others.\textsuperscript{111}

There is a dearth of knowledge regarding sexuality and sexual behavior of older adults. The widely held belief that older adults are not

The burden of discrimination and poverty increases the likelihood of substance use, such as alcohol, cocaine, crystal meth, and intravenous drug use, as methods of coping with life stressors.\textsuperscript{98} Studies conducted in Chicago and San Francisco revealed a high prevalence of heavy alcohol and drug use among transgender populations.\textsuperscript{99, 102} Further, substance use was positively correlated with higher rates of unprotected anal intercourse.\textsuperscript{101}

Addressing HIV among transgender women requires greater surveillance and HIV prevention efforts tailored to transgender populations. Research to date on public health issues affecting MSM has largely neglected transgender persons.\textsuperscript{102} Additionally, a lack of culturally competent health care providers has prevented transgender women from accessing health care and from receiving information regarding STI and HIV prevention.\textsuperscript{103} Sensitization of health care professionals regarding the specific health issues unique to transgender persons, as well as HIV prevention efforts targeted toward transgender women are essential to curtail the spread of the virus among this population.

**Sexual Identity and Behavior among Youth and Aging Populations**

Research on sexual identity, behavior, and ethnic and racial differences among young men who have sex with men has been limited. Existing research suggests commonalities and differences in the development of sexual identity over time.
sexually active, and the presumption that they are heterosexual, inaccurately homogenizes this population and is detrimental to LGBT elders who may be more vulnerable to neglect, discrimination and abuse.13

Many gay men experience aging differently than their heterosexual peers. Some gay men experience “accelerated aging.” That is, they experience themselves as old at an earlier age than their chronological age.13 This factor is especially relevant for men who base their experience of social acceptance and life meaning in physical attractiveness and desirability, which is often equated with youth. Gay men over 40 who are single and struggling with social isolation, within the context of gay male social culture’s emphasis on youthfulness, may put themselves at risk for HIV through the ways they meet men for social and sexual experiences, such as meeting anonymous partners on the Internet and coupling their experiences with substance use.

**Sexual Identity and Behavior among Foreign-Born MSM**

The term “sexual migration” describes “international relocation that is motivated, directly or indirectly, by the sexuality of those who migrate.”14 Both male and female migrants to the United States have reported experiencing greater sexual freedom and fewer restrictive gender norms in the U.S. than in their countries of origin.15

A recent study in *Culture, Health and Sexuality* looked into how social context influenced the behavior of Latino men who have sex with men who had migrated to the United States.16 The study found that Latino men who had sex with men tend to immigrate to the United State to escape negative perceptions about homosexuality in their home countries. It also suggested that these Latinos moved to the United States to achieve greater sexual freedom. Many of the men in the study experienced being in what the study describes as “gay epicenters” (such as New York City) as liberating and conducive to sexual exploration because of the anonymity that breaking past connections afforded. Indeed, immigrant MSM, especially young MSM, tend to engage in high levels of sexual activity soon after arriving in New York City. The study concluded that the initial years after immigration represent a period when Latino MSM are particularly vulnerable to contracting HIV, and that particular attention needs to be focused on this population at this point in their lives.

According to the New York City Department of Health and Mental Hygiene (DOHMH), 36% of New Yorkers are foreign-born, and most foreign-born adults come from Latin America and the Caribbean. In 2007, 27% of all new HIV diagnoses in New York City were among foreign-born New Yorkers. From 2001 to 2006, the share of New Yorkers newly diagnosed with HIV who are foreign-born increased from 17% to 27%.17 The top five countries represented were the Dominican Republic, Jamaica, Mexico, Haiti, and Trinidad & Tobago.18

For foreign-born male New Yorkers, the main transmission risk was the same as for native-born men, MSM, at over 80% of all men.19 The ratio of diagnoses of males to females diagnosed with HIV is about 2:1 for foreign-born New Yorkers and about 3:1 for non-foreign-born.20 The increased incidence in HIV among foreign-born New Yorkers highlights the need for culturally competent and effective prevention efforts aimed at recently immigrated men in gay epicenters throughout the U.S.

**Risk Factors**

**Context: Most Gay Men Practice Safer Sex**

While it is important to stress the disproportionate impact of HIV on gay and bisexual men, we must not pathologize gay men in the process. Public health officials often ask, “Why are gay men having unsafe sex? What is wrong with them?” Even within the gay male community, recently diagnosed HIV-positive gay men report high levels of stigma against them for having gotten HIV, perhaps higher than existed 15 or 20 years ago, because they should have “known better.”

In *What Do Gay Men Want: An Essay on Sex, Risk, and Subjectivity*, David Halperin reviews much of the recent literature on sex and behavior and notes that “safe sex” was “a gay, grassroots invention” of the early 1980s,
In 2008, over 80% of both foreign-born and non-foreign-born males diagnosed with HIV had MSM risk. There was a larger proportion of IDU among non-foreign-born than foreign-born males.

Perinatal transmission accounts for less than 1% of transmission risk in this population. As reported to the New York City Department of Health and Mental Hygiene by September 30, 2009.
from a time even before the workings of HIV were well understood. Indeed, the literature overwhelmingly shows that most gay and bisexual men do have safe sex, and at twice the rate of heterosexuals. David Nimmon’s 2002 analysis of more than 60 behavioral studies published during the 1990s found that between 60% and 70% of gay men used condoms when having sex, compared with a third or less of heterosexual men and women. Other meta-analyses published between 2000 and 2003 similarly found that gay men have safe sex at twice the rate of the general population.

Two recent studies found that HIV-negative gay and bisexual men overwhelmingly practice safe sex. Kane Race found that 91% of a sample of HIV-negative and untested MSM had not “intentionally set out to have unprotected anal sex with someone other than a primary partner” in the last two years. Studies from San Francisco and Seattle found that about 90% of HIV-negative MSM had not had unprotected anal sex with another man in the past two years (San Francisco) or one year (Seattle), respectively.

Social and Economic Factors

Social and economic factors have a direct impact on the health of all gay and bisexual men, and particularly gay men of color. These factors have been shown to influence behavior that may increase the risk of HIV infection and therefore must be considered when evaluating which HIV-prevention interventions will best meet the needs of gay and bisexual men.

The socioeconomic problems associated with poverty—including homelessness and unreliable transportation; limited or no access to high-quality health care; the exchange of sex for drugs, money, or other needs; and higher levels of substance use—often lead directly or indirectly to increased HIV risk among gay men and other MSM. The disproportionate impact of HIV on the black community has also been linked to the consequences of marginalized social status and poverty, including higher risks for homelessness, drug use, incarceration, and risky sexual behavior, all of which contribute to HIV infection and transmission.

How these poverty-related risks become compounded for MSM can be seen in the homeless lesbian, gay, bisexual, and transgender (LGBT) youth population, of which there are 3,000 to 8,000 living in New York City (based on estimates that 20% to 40% of all homeless youth are LGBT). A 2007 report by the National Gay and Lesbian Task Force Policy Institute and the National Coalition for the Homeless noted that substance abuse is not an isolated outcome automatically causing or resulting from homelessness. Rather, it is inextricably linked to other behavioral, health, and mental health concerns. Chronic stressors, inherent in the daily life of homeless youth, along with the social stigma experienced by LGBT youth in general, lead to substance abuse at alarmingly high rates when compared with the general population. Additionally, a study of MSM found that homelessness was associated with less frequent condom use, whereas community connectedness was associated with a greater likelihood of condom use. (See “Community Connectedness,” under “Resiliency Factors,” for more on this important topic.)

Substance Use and Abuse and HIV Risk

Bars have often functioned as “community centers,” particularly for those who want to hide their involvement in a community of gay and lesbian people. Bars and clubs often still serve as prime social centers for people, straight and gay alike, to socialize, meet for dating, and/or to hook up to have casual sex. Many men have identified the values that alcohol offers, such as a lessening of anxiety and nervousness in order to feel more confident in meeting other men. In addition, alcohol and drugs can offer feelings of exhilaration, euphoria, disinhibition, and heightened sexual desire. Besides its value as a

Most gay and bisexual men have safe sex, and at twice the rate of heterosexuals.
“social lubricant,” gay men report that drug use helps them cope with external and internalized homophobia, low self-esteem, feelings of alienation, stress related to having or worrying about getting HIV/AIDS, depression, anxiety, and attention deficit hyperactivity disorder (ADHD).

A random chart sampling of the 2,519 gay and bisexual men who received a biosocial intake at GHMC in 2007 shows high rates of substance use. The biosocial intake is a standardized GMHC tool used at the onset service delivery to identify social and economic factors of the client. Of the 50 charts sampled (25 HIV-positive, 25 HIV-negative), 78% had a history of drug or alcohol use, with alcohol, marijuana, and cocaine being the most commonly used substances.

Studies strongly indicate a higher prevalence of “high risk” sex—sex with multiple partners and/or sex without condoms, which increases the exposure to STIs—while one is high or under the influence of drugs and/or alcohol. Drugs and alcohol also carry the risk of dependence. Drug use can lead directly to HIV transmission (injection-drug use), or it can facilitate sexual risk-taking (any drug use). Non-injection drug use in the MSM population increases the risk for HIV transmission as it encourages risky sexual behaviors; substance users report more sexual partners and are less likely to use condoms. The National HIV Behavioral Surveillance (NHBS) System, which collected risk behavior data from approximately 10,000 MSM across the U.S. from November 2003 to April 2005, reported the following:

- 43% of MSM reported using a non-injection drug during the preceding 12 months.
- The most common drug used was marijuana (77%), followed by cocaine (37%), ecstasy (29%), poppers (amyl nitrate) (28%), and stimulants (27%). (The NHBS did not include the use of alcohol in risk behavior data; see following paragraph for some data on alcohol use.)
- Among those who used, 74% reported being under the influence of a drug during sex during the preceding 12 months.
- Of those who used during the preceding 12 months, only 16% had ever participated in a drug or alcohol treatment program.

In a report on alcohol use and risky sex in New York City, the New York City DOHMH found that one in four (24%) MSM say they binge drink, compared to one in seven adults (15%) city-wide. Also, MSM who binge drink were twice as likely as non-drinking MSM (40% versus 21%) to report having five or more sex partners in the past year. This report also drew on local data from the National HIV Behavioral Surveillance System, which is based on interviews with MSM in gay bars and other venues. While not representative of MSM on the whole, the interviews indicated that 27% of the men who had casual partners said they were under the influence of alcohol during their last sexual encounter, and 12% were under the influence of both alcohol and drugs. Among men who reported having 20 or more sexual partners in the past year, almost half (48%) were under the influence of alcohol the last time they had sex. Drinking alcohol also reduced the chances (from 86% to 65%) that a man having receptive anal intercourse would use a condom.

The Demographics of Substance Abuse and HIV Risk

The CDC-sponsored Young Men’s Survey found that being under the influence of alcohol, marijuana, amphetamines, or cocaine during sex was significantly linked to unprotected sex. This study documents that young MSM are significantly more likely than their heterosexual peers to report lifetime and recent (within the past 30 days) substance use, and are more likely than their heterosexual peers to report the use of alcohol or other drugs before sex, which increases the likelihood of participation in unprotected sex.

GMHC and AIDS Project Los Angeles (APLA) conducted a study of 416 gay and bisexual men of color ages 18–24 at Pride events in July 2006 and June 2007. The study found that 57% of those men of color who reported having sex within the previous three months had used substances during sex. Alcohol was the most commonly used substance (60%), followed by marijuana (30%). Twenty-six percent reported using multiple drugs during sex. Alcohol, crystal methamphetamine, and ecstasy were negatively associated with condom use.

A recent large-scale HIV vaccine efficacy trial looked at combinations of demographic
characteristics and risk behaviors to help identify MSM at greatest risk for HIV infection. This study of more than 5,000 HIV-negative MSM found that older men with large numbers of sex partners, young men who used “party” drugs (such as ecstasy and GHB), and older men who used nitrate inhalants (poppers) were most likely to contract HIV.

GMHC’s own research supports these data. A study of young (age 24 and under) MSM in the New York City’s House and Ball community found that alcohol and marijuana use affected the choices young gay men and MSM make when they are having sex. In unpublished, community-based research we conducted in 2006 to inform the development of a crystal methamphetamine prevention social marketing campaign, we found that the following factors impacted the use of crystal meth among MSM of color: low self-esteem, curiosity, homophobia, isolation, escapism, and stress/depression coping mechanisms.

Substance Use Prevention among Gay Men

Impaired judgment regarding safer sex behavior may be an occasional experience and not necessarily related to substance abuse and the need for drug or alcohol treatment. However, because substance use is so pervasive, and because it so clearly impacts risk behavior, it must be central when determining approaches to HIV prevention with gay men.

Substance use counseling, education, and treatment must be made available to gay and bisexual men. Among the most effective approaches are those that address drug and alcohol use from a harm reduction perspective. Harm reduction counseling is based on a set of practical strategies to reduce negative consequences of drug use, incorporating a wide range of strategies including safer use, managed use, and abstinence. Counseling from a harm reduction approach addresses substance use in conjunction with the contextual factors of use and asks drug users to identify goals ranging from managing their substance use to changing it to completely abstaining from use.

Short-term substance use services, such as one-on-one and group counseling, must be made available to HIV positive and high-risk negative gay and bisexual men who use alcohol and drugs. Such services should offer a supportive environment for individuals to identify goals and to explore contextual factors of their use, in order to change their drug use and understand its relationship to their sexual behaviors. They should employ proven psycho-educational approaches, such as cognitive behavioral techniques, and provide a safe space to identify goals.

For those in whom substance use has progressed to abuse and addiction, substance use treatment may require inpatient or outpatient care. These individuals will require services such as addiction treatment, including residential treatment, outpatient treatment, and hospital inpatient programs for drug addiction and alcoholism. It is critical that treatment programs be culturally competent to serve

How obvious does it have to get...

...for us to talk and care about each other?

GMHC substance use prevention campaign, 2008.
the specific needs of gay men; currently, few are specifically geared toward serving gay men or MSM. Treatment programs should take advantage of services such as those provided by the Substance Abuse and Mental Health Services Administration (SAMHSA)'s Center for Substance Abuse Treatment, which offers cultural competency training regarding sexual orientation and gender identity. Some substance abuse treatment programs have refused to admit patients with a history of MRSA, though this does not pose a health risk (for more on MRSA, see the next section, “Sexual Health Contextual Factors”). Because gay men and people living with HIV are more likely to get MRSA, this practice represents a significant barrier to gay men’s ability to access treatment. Moreover, long-term substance abuse treatment should be affordable to gay men of all income levels. Insurance companies should not deny coverage to those in need. It is often a struggle to get insurance companies to cover treatment.

Other Sexual Health Issues

Syphilis

Sexually transmitted infections (STIs) continue to take an especially heavy toll on MSM, according to the CDC’s Sexually Transmitted Disease Surveillance 2007 report. The report noted that 65% of new syphilis infections in 2007 occurred among MSM. In New York City, after plummeting during the 1990s, syphilis cases started rising in 1999. The rate leveled in 2005 and 2006 but is now moving upward again. In the first three months of 2007, New York City DOHMH reported 260 new cases of primary and secondary syphilis, compared with 128 cases during the same period in the previous year. Interviews with patients suggest that the increase indicates an actual outbreak of syphilis among gay and bisexual men, especially in the Chelsea area of Manhattan.

Gay and bisexual men must be vigilant and get tested for syphilis on a regular basis, even if they experience no symptoms. Syphilis left untreated makes it easier to become infected with and transmit HIV.

MRSA

MRSA, or methicillin-resistant Staphylococcus aureus, is a strain of staph that is resistant to the broad-spectrum antibiotics commonly used to treat it. A strain called USA300 has been a leading cause of community-acquired MRSA in this decade, and an exceptionally virulent drug-resistant variant of it has been seen to have a specific prevalence among men who have sex with men, especially within gay communities in San Francisco, Boston, and New York City.

New York City doctors first spotted the original USA300 during tests for patients treated at a walk-in clinic for skin infections in 2001. Since
then, they have watched it morph from laboratory curiosity into the dominant form of staph infection in much of the United States.

Staph infections are usually treatable, but some, including USA300, can be lethal. USA300 can cause abscesses and skin ulcers and can produce necrotizing fasciitis, or flesh-eating bacteria. Beyond that, it can attack organs causing pneumonia, heart damage, and blood infections. Topical infections have even resulted in the amputation of fingers, toes and limbs.

USA300 is resistant to six major antibiotic classes and is resistant to two of the three alternative MRSA treatments recommended by CDC and the Infectious Diseases Society of America. Its most disturbing trait, however, is just how easily it gets around.

Researchers reported that in San Francisco, MRSA USA300 spread most often through anal sex, but also was spread through casual skin-to-skin contact or touching contaminated surfaces. Among the men in this study, MRSA was spread through skin-to-skin contact and caused abscesses and infection in the buttocks, genitals, and perineum (the space between the scrotum and anus). The study authors note that the same risk behaviors that are of concern for recent increases in HIV infection and syphilis are also associated with the spread of USA300: the use of crystal methamphetamine and other drugs, sex with multiple partners, participation in group sex parties, Internet-initiated sexual contacts, sexual activities that cause skin abrasions, and a history of STIs. Men who travel to San Francisco and engage in these higher risk sexual activities may also be at risk, because many cases of USA300 have been diagnosed among MSM there.

The possibility that the infection will go national is a big concern. Nearly 19,000 people died from MRSA infections in 2005, mostly from a weaker form of USA300, and the study’s lead researcher suggested that the more virulent form could “spread to the general population.” The new, multidrug-resistant strain of USA300 “is presently rare” in the general population, according to the study, and there is reason to believe it is spreading “exclusively” among gay men. However, this does not mean that only gay men are at risk.

65% of new syphilis infections in 2007 occurred among MSM.

Both individuals and institutions can take measures to prevent MRSA from spreading. For example, washing thoroughly with soap and water before and after sex prevents against skin-to-skin transmission of MRSA (although this does not prevent infection with HIV). Researchers recommend that emergency department physicians treating MRSA infections should test for drug resistance to avoid using the wrong antibiotic and causing further resistance. Gay and bisexual men and other MSM, along with the general population, sorely need widespread education about this extremely dangerous infection. Moreover, targeted HIV prevention efforts that succeed in reducing high risk behaviors are likely to cause a decline in MRSA transmission as well.

Anal Cancer

There are 4,650 cases of anal cancer each year in the United States. Overall, this is slightly less than 2 cases per 100,000 people. In gay and bisexual men, however, the rate of anal cancer is 35 per 100,000, and in HIV-positive MSM the rate is 80 per 100,000. This means that the relative risk of anal cancer among HIV-positive MSM and HIV-negative MSM is 40 and 20 times higher, respectively, than in the general population.

The human papilloma virus (HPV), which causes genital warts in both men and women, has been associated with the development of penial and anal cancer in men. In October of 2009, the FDA approved the use of an HPV vaccine for males ages 9 through 26 to prevent genital warts. Recently, a large clinical trial that studied a cohort of young HIV-positive men, and a cohort of young MSM, showed that the HPV vaccine was effective in preventing genital and anal infection in participants of both groups. These strains of HPV differ than the strains of HPV that cause anal cancer. However, it is possible that the HPV vaccine may prevent cancers of the anus, as well.
Gay Men and HIV: An Urgent Priority

Resiliency Factors

MSM can develop healthy identities and behaviors despite interpersonal, cultural, or social stressors attributed to sexual orientation or gender identity. Qualitative studies investigating the lives of young MSM, older adult MSM, and MSM of color identify a number of positive coping mechanisms that are developed within highly stressful environments. Research shows that resiliency factors lead to better health outcomes for MSM over the course of their life. The following section identifies systems which support the development of healthy gay and bisexual men’s identity and leads to less high-risk sexual behavior.

House of Latex Ball

GMHC has effectively used the community-events approach to HIV prevention in work with the New York House and Ball community, which includes young gay men and MSM of color, two especially high-risk populations. Since 1989, GMHC has worked with the House and Ball community and in 1991 began hosting the annual House of Latex Ball, a large multimedia event in which participants compete for trophies in different performance categories. At this event, which has drawn up to 3,000 participants, video PSAs run prevention messages, volunteers distribute social marketing materials throughout the venue, competition categories include HIV prevention themes, and local leaders and performers make HIV-awareness statements. HIV testing is also offered on-site, attracting 80 to 100 persons at each event. Throughout the remainder of the year, similar but smaller-scale mini-balls and monthly “Kiki Functions” provide an ongoing connection to this population to reinforce prevention efforts.

Community events also provide an ideal medium for launching social marketing campaigns. Social marketing campaigns that address themes such as HIV stigma, homophobia, connection, and love resonate more powerfully with audiences when presented at formal events, through various forms of artistic expression and in conjunction with respected figures in the community. Such events can be held in neighborhoods where the target populations socialize and live, and in a variety of venues, including cafés and performance spaces. They can include spoken-word and open-mic performances, art and photography exhibits, and music concerts, which relate in theme to the campaign being showcased. The participation of artists and collaborators who are well known and highly regarded members of the target communities can provide a significant draw to these events.

Community Connectedness

Community connectedness has been proven to have a protective HIV effect—that is, to reduce HIV transmission—among gay and bisexual men and can be a key tool in HIV prevention. Greater community involvement is believed to counter the negative effects of poverty, racism, and homophobia on safer sex practices among MSM through social support, feelings of self-efficacy and positive self-identity, and peer norms oriented towards safer sex practices.

In 2008, the Massachusetts Department of Public Health funded the Fenway Institute to implement a pilot program to evaluate the initial efficacy of a group intervention to reduce HIV sexual risk, depression-related withdrawal, and anxiety-related social avoidance in gay and bisexual men age 40 and older. The intervention, titled “40 and Forward,” was a series of 2-hour weekly sessions that brought together groups of 15-18 gay men, ranging between 41 and 79 years of age, and of multiple races, to address topics including: activity scheduling and anticipating obstacles; safer sex and decision-making; and active listening and social interaction, among others. Four groups in total were assembled, with two groups participating in a 4 week intervention and two other groups participating in a 6 week intervention. Preliminary findings revealed that the program had moderate effects on psychosocial outcomes. Men who participated in the 4 week intervention reported a significant decrease in depressive symptoms. Additionally, participants of the 6 week intervention reported a significant increase in condom use self-efficacy. In addition, the intervention helped socially isolated older gay men develop social support networks, a critical resiliency factor regarding HIV and general well-being.
Greater involvement in gay communities and attachment to an ethnic community, as well as supportive peer norms, have also been observed to be protective for safer sex behaviors among Latino and black MSM. In 2006–2007 GMHC and APLA conducted a study to gather data on the substances black and Latino young men who have sex with men (YMSM) use and associate with sex in their communities. YMSM were asked about the extent to which they felt connected to other YMSM of color. Overall, feelings of connectedness to peers were moderate, with 10% feeling not at all connected, 19% feeling a little connected, 31% feeling somewhat connected, and 41% feeling very connected. Latino and multiracial YMSM felt more strongly connected to other YMSM of color than did black YMSM. Feelings of community connectedness were positively correlated to condom use.

The protective effect of community connectedness for condom use corroborates previous studies finding similar relationships between community involvement and safer sex behaviors. This increasingly robust finding suggests the importance of addressing social networks and peer-based HIV prevention programs for black and Latino YMSM. Of course, community connectedness is more likely to have a protective effect where YMSM are integrated into social networks with people who tend toward safer sex practices, whereas those networks in which people tend toward risky sexual and substance use behaviors may actually increase risk behavior in others. Through repetition and over time, high-risk behaviors may come to seem less risky than they are. The YMSM in our study were encountered at LGBT-identified and racially identified events (e.g. Gay Pride, Black Gay Pride, etc.), and the peer education and other services provided by LGBT organizations that reinforce safe sex practices likely increased feelings of community connectedness.

HIV prevention efforts must therefore include support for building on these social systems by providing culturally tailored sexual health programming, particularly at racial/ethnic-specific gay pride events. Working with community leaders and creating more opportunities for dialogue about sexual identity, behavior, and HIV issues in black communities will also bring the benefits of social support and community connectedness to the young black gay men who are most at risk.

**Family Acceptance**

How families respond to adolescents’ coming out strongly affects adolescent health, mental health, and development for gay or bisexual young people. People are coming out at increasingly younger ages. This significantly increases the risk of victimization and abuse in family, school, and community settings, yet it also provides prime opportunities for helping to support and strengthen families.

The family is the primary support for children and youth, and family involvement helps reduce adolescent risk and increase resiliency. A 2009 *Pediatrics* study by Caitlin Ryan et al. documented for the first time that the victimization of lesbian, gay, and bisexual (LGB) youth has long-term consequences for health and development, and it impacts families as well as the targeted individuals. The study examined nine negative health indicators—including mental health, substance abuse, and sexual risk—and established a clear link between specific parental and caregiver rejecting behaviors and negative health problems in young LGB adults. Greater experiences of family rejection were associated with poorer health outcomes.

This study suggests important recommendations that can support positive health outcomes for LGB youth and young adults. Providers working with LGB youth should address family dynamics and consider the role of families when assessing risk and making decisions about their care. Counseling families and providing support and guidance for them can decrease risk and increase the health and well-being of LGB youth. Early intervention can help families and caregivers build on strengths and use evidence-based materials to understand the impact of acceptance and rejection on their child’s well-being.

Innovative social marketing is one effective and powerful way to reach families with messages encouraging family acceptance. For example, GMHC’s “My Son Is My Life” campaign demonstrates the importance of parental support in the lives of gay men of color.
School Acceptance: Combating Anti-LGBT Harassment and Violence

Research shows that LGBT-affirming school-based interventions, such as Gay-Straight Alliances (GSAs) and antibullying initiatives, are key resiliency factors for gay youth. Young gay and bisexual men in schools with pro-gay interventions report less risky behaviors associated with HIV transmission, including unsafe sex.

The threat of violence and harassment makes school an unsettling and unsafe place for LGBT students. Social science researchers and youth advocacy groups agree that harassment of LGBT students is rampant. Human Rights Watch estimates that each year two million American students are bullied because they are gay or are thought to be gay. Some gay youth find it difficult to concentrate in class and focus on schoolwork. Many, fearing discovery of their sexual orientation or gender identity, hesitate to participate in school activities. As a result, they distance themselves from the school environment both emotionally and physically; some become truants or drop out altogether. This has a lasting, negative impact on LGBT youth, inhibiting their development and their successful transitions to adulthood.

The harassment and violence that LGBT students experience has a negative impact on their mental and physical health in indirect ways as well. A 2002 study indicated that lesbian, gay, bisexual, and questioning youth who experienced three or more incidents of harassment within the preceding year engaged in behaviors that put their health at risk at a higher rate than their heterosexual peers who were similarly harassed. Stress caused by victimization and isolation, and the lack of positive sources of peer support and socialization, may also cause students to engage in unprotected sex or other risky sexual behaviors, which increases their risk of contracting STIs, including HIV. A Minnesota study (conducted from 1989 to 1991) of gay and bisexual young men ages 13–21 found that nearly one quarter had had an STI; in a San Francisco study, almost one third of gay and bisexual young men reported at least one STI. A study of 334 homeless and runaway adolescents and young adults in San Francisco found that 33% of the gay and bisexual males and 3% of the lesbian and bisexual females were HIV-positive, as opposed...
to 1% of the heterosexual males and none of the heterosexual females in the study.\textsuperscript{183}

Schools must adopt gay-affirming interventions and work to address anti-LGBT harassment and violence. Such programs have an important impact on factors related to HIV prevention among youth. Interventions that counteract and prevent anti-LGBT violence in public schools include GSAs, nondiscrimination policies, anti-bullying curricula, and curricula designed to provide positive and inclusive examples of the contributions that LGBT people have made to American and world culture.

A variety of policies and support systems can help communities combat and eventually eliminate anti-LGBT harassment and violence in their public schools:

- The Equal Protection Clause of the U.S. Constitution and existing federal laws, including Title IX of the Education Amendments Act of 1972, and the Equal Access Act of 1984, offer LGBT students some protection from harassment and violence, as well as the freedom to create and attend gay-supportive clubs on school campuses.\textsuperscript{184}
- School districts can implement and enforce nondiscrimination and antiharassment policies that protect LGBT students and teachers.
- Teachers can include LGBT culture and history in curricula, and create a safe environment by not tolerating anti-LGBT harassment; those who are either LGBT or LGBT-friendly can also serve as role models for both their gay and straight students and coworkers.\textsuperscript{185}
- GSAs or other support groups can give LGBT students and their straight allies a place to meet on school property in a safe and supportive environment; their very existence is symbolic of a school's commitment to a safe and inclusive environment for all students.

Combined, these resources can comprehensively meet the needs of LGBT students. A pilot study of the Massachusetts Safe Schools Program found that clear nondiscrimination policies, backed by financial resources and support from key administrators, educators, and community and student leaders, are at least as important as GSAs in creating more tolerant and safer environments for LGBT students.\textsuperscript{186} The decentralized nature of the U.S. public education system demands that each individual school district act to implement such measures, especially because efforts to mandate these protections and curriculum changes at the federal level have been largely unsuccessful.

**State and Local Policies**

Without the formal protection of nondiscrimination and antiharassment policies that specifically mention sexual orientation and gender identity, students may justifiably continue to fear discrimination, including harassment, because they are LGBT. Including sexual orientation and gender identity in nondiscrimination and antiharassment policies makes LGBT students feel welcome, and encourages the kind of social change that makes schools safer.\textsuperscript{187, 188, 189}

As of 2010, fifteen states and the District of Columbia have passed laws banning
discrimination and/or harassment of students on the basis of sexual orientation. Twelve states and the District of Columbia prohibit discrimination and/or harassment in schools on the basis of gender identity or expression as well. Five states have promulgated professional standards for educators that forbid discrimination against students on the basis of sexual orientation: Alaska, Florida, Massachusetts, Pennsylvania, and Utah. At least five other states (Hawaii, Maryland, Oregon, Pennsylvania, and Rhode Island) have adopted nondiscrimination and/or antiharassment regulations or ethical codes through state administrative regulations. Unfortunately, none of these regulations prohibits discrimination or harassment on the basis of gender identity. Finally, 28 states have passed laws that prohibit harassment, intimidation, and “bullying” in schools but do not specifically enumerate any categories of protection.

**Staff Development and Training**

The failure of many teachers and counselors to serve LGBT youth originates from a lack of training. Advocacy groups and educators who support the inclusion of training on sexual orientation and gender identity and expression in tolerance programs assert that prejudice and harassment can only be overcome by talking directly and frankly about the issue and through providing resources for in-school mentoring and support. Thus, staff training is an essential tool for creating a school atmosphere free of anti-LGBT harassment and discrimination. School staffers must be able to assist students who are struggling with their own, or another’s, sexual orientation or gender identity. And they must be able to identify and intervene on behalf of students who are harassed or discriminated against or who face detrimental health consequences as a result of prejudice. In addition to providing the tools to deal with such situations, training gives teachers, administrators, and other staffers the opportunity to work out their feelings related to sexual orientation and gender diversity and learn how to handle the discomfort of colleagues, students, and parents around such issues.

**Safe Schools Programs**

Massachusetts launched the country’s first safe schools initiative in the early 1990s, after the Governor’s Commission on Gay and Lesbian Youth documented the hostile school climate pervasive in most of the state’s schools and its negative impact on gay and lesbian students, the children of gay parents, and other students who were perceived as somehow different. The Safe Schools Program sought to fulfill four recommendations made by the Massachusetts Board of Education in 1993:

1. Develop policies that protect gay and lesbian students from harassment, violence, and discrimination.
2. Offer school personnel training in violence prevention and suicide prevention.
3. Offer school-based support groups for gay, lesbian, and heterosexual students.
4. Provide school-based counseling for family members of gay and lesbian students.

The Massachusetts legislature appropriated funds to support the Safe Schools Program through the Departments of Education and Public Health. Within a few years, more than 140 schools across the Commonwealth had GSAs, and many teachers and counselors were trained in how to deal with antigay harassment and violence. The program showed results very quickly. One study found that in schools with GSAs, 35% of students said gay, lesbian, and bisexual students could safely choose to be open about their sexuality. In schools without GSAs, only 12% said students could openly identify as lesbian, gay, or bisexual safely. The study also discovered that in schools where the faculty had undergone training on gay issues, 54% of students said that gay students felt supported by teachers and counselors; in schools that had not undergone faculty training, only 26% of students said gay students felt supported.

**Gay-Straight Alliances**

As of 2010, there were more than 4,000 gay-straight alliances in U.S. schools registered with the Gay, Lesbian, and Straight Education Network (GLSEN). GSAs are in-school, extracurricular groups that support LGBT students, those questioning their sexual orientation or gender identity, and their straight friends and allies. They are an important part of an overall strategy to
The GSA at East High School in Salt Lake City had a positive impact on students’ academic performance and enhanced their sense of belonging to the school community.

ensure that schools provide education in a safe and welcoming environment. GSAs, which are always student-initiated, bring together students and school staff to end anti-LGBT bias and homophobia or transphobia in their schools. They are the most visible and widely adopted component of safe schools programs.

GSAs are often the only school-based place where LGBT youth can safely discuss problems associated with their sexual orientation or gender identity, and they foster communication with others who understand what they are going through. Students are thus able to make friends without hiding their sexual orientation or gender identity, helping them develop social skills and self-esteem. GSAs also increase interest in learning about cultural and social issues related to sexual orientation or gender identity among LGBT students and their allies. Even students who do not actively participate in GSA activities benefit from their presence. According to one teacher and GSA advisor, “at least they know there is a safe place; someone is acknowledging them and the issues they face.”

A study involving seven students from the GSA at East High School in Salt Lake City found that the GSA had a positive impact on students’ academic performance and enhanced their sense of belonging to the school community. The students’ sense of physical safety improved as well. Several students reported that they attended school more often following their involvement with the GSA, and that they worked harder when they were at school. They also improved their relationships with their families and at school, developed a higher comfort level with their own sexual orientation, learned strategies for dealing with others’ presumptions about their sexuality, and felt better about their ability to contribute to society.

A study of the Massachusetts Safe Schools Program found that the presence of GSAs made a positive difference. In those schools with a GSA, 52% of the students indicated that there were members of the faculty, staff, or administration who supported LGB students, in contrast to only 37% of students in schools without a GSA. Students in schools with a GSA were also more comfortable referring a friend with questions about sexual orientation to a counselor. And staff in schools with a GSA were more comfortable assisting students with questions about sexual orientation.

A 2003 study of GSAs in 22 schools describes four key roles that GSAs can play in the school environment:

**Counseling and support:** Two of the GSAs in the study served as places where students could meet as a group or individually with the GSA advisor. These GSAs focused on assisting students with issues about sexual orientation or gender identity.

**Creating “safe” space:** Six of the GSAs became highly visible throughout the school through announcements over the school’s public address system and posters advertising their meetings. Their goal was to provide a place where students could socialize and talk about common interests and experiences. Typical activities included watching movies, eating pizza, listening to an invited speaker, and discussing school safety issues. (Students of color or students who were
not openly gay were underrepresented in these GSAs. The authors of the study consequently used the word “safe” in quotation marks to underscore that not all students felt safe and included there.

**Raising awareness, educating, and increasing visibility:** Nine of the GSAs had regularly scheduled meetings that included both social and educational or political activities. These groups were not only visible through announcements and posters, but also played a lead role in calling attention to safety issues affecting LGBT students. These GSAs initiated LGBT-supportive school programming and lobbied for staff training; students planned school-wide assemblies that addressed LGBT issues and visited classrooms to talk to their peers.

**Becoming part of broader efforts:** Five of the GSAs partnered with other schools, community members, or groups addressing LGBT issues. School-based safe schools task forces composed of staff members, parents, and students took on a primary role and sponsored community-wide and school-based projects, such as administering school climate surveys to students. In partnership with the GSAs, these organizations also developed mandatory staff development programs on LGBT issues, and they facilitated the inclusion of LGBT curricula in the classroom. The staff in these schools also created intervention strategies for ending anti-LGBT harassment and fought for the inclusion of domestic partnership benefits for LGBT staff. 211

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**I know my rights... do you?**

Transgender Healthcare Discrimination

In New York City, it is against the law for a “place of public accommodation,” which includes hospitals, clinics, doctors’ offices, dentists’ offices, and therapists’ offices, to discriminate against transgender and gender nonconforming people.

A healthcare provider should never refuse to treat you because you are transgender. Sometimes doctors claim that they will not treat you because they do not have enough “expertise” in treating transgender people or because transgender people have “special needs.” That may be an okay reason if you are seeking specific complex care related to being transgender, such as a type of sex reassignment surgery that the doctor does not know how to do. But, if you are looking for a type of care the doctor provides to non-transgender people, such as breast enhancement, gynecological exams, or treatment for illness or infection, the doctor may not use his or her failure to treat transgender people in the past as an excuse to discriminate against you now.

If you believe you have been the victim of discrimination in New York City, you should first find out if the hospital or healthcare provider’s office has an internal way to file a grievance. Some have a patient advocate office that may be able to help you. You may also file a complaint with the Law Enforcement Bureau of the City’s Commission on Human Rights. For more information, please visit http://www.nyc.gov/html/chr/ or call 212-306-7400. The law requires that the complaint be filed within one year of the last alleged act of discrimination.

www.gmhc.org
HIV Prevention

History of CDC Policy

Given the rising numbers and disproportionate incidence and prevalence of HIV and AIDS among gay men and other MSM, the CDC must recommit to supporting HIV prevention at levels that reflect the reality of the current urgent need. To provide context for the HIV prevention efforts and initiatives we call for at the conclusion of this paper, in this section we review the history of CDC policy and programs in relation to HIV prevention.

CDC Policies and Programs in the 1980s

Over the years the governmental response to HIV/AIDS has changed as the public health impact of HIV has evolved. In the early 1980s AIDS became stigmatized as a gay condition because, at least in the United States, it was first observed among gay men who showed unexplained cases of a rare pneumonia (pneumocystis carinii pneumonia) and a rare skin cancer (Kaposi’s sarcoma). Gay Related Immuno-Deficiency (GRID), the name first given to the disease, was changed to Acquired Immune Deficiency Syndrome (AIDS) by CDC scientists in 1982. However, the initial stigma of AIDS as a gay disease persisted; in addition, AIDS was feared because it was seen as an inevitable death sentence. In fact, by 1994 AIDS became the leading cause of death for all Americans ages 25 to 44.212

The advent of highly active antiretroviral therapy (ART) in 1995 resulted in a dramatic change in how HIV/AIDS was perceived. As early as 1996 HIV was no longer the leading cause of death for all Americans in the 25–44 age group, but it did remain so for African Americans in this cohort. In the following year AIDS deaths had declined by more than 40%, largely due to ART.213 This shift changed the perception of HIV: It was no longer viewed as a certain death sentence; it could be treated. This also led to a shift in how people viewed HIV testing, given that there were now effective treatment options available to those who tested positive.

At the onset of the epidemic a climate of fear persisted as more and more people succumbed to AIDS. As early as 1983 the CDC and U.S. Public Health Service began to emphasize prevention and issued recommendations for preventing transmission through sexual contact and blood transfusions.214

CDC Policies and Programs in the 1990s

In 1994 the CDC changed the manner in which federally funded state and local level HIV prevention programs were planned and implemented. State, territorial, and local health departments receiving federal prevention funds through CDC were asked to share with representatives of affected communities and other technical experts the responsibility for developing a comprehensive HIV prevention plan using a process called HIV Prevention Community Planning. The basic intent of the process was threefold: to increase meaningful community involvement in prevention planning, to improve the scientific basis of program decisions, and to target resources to those communities at highest risk for HIV transmission/acquisition.215 The CDC expected that a decentralized approach to community planning would maximize participation and the sharing of leadership.216 Through the principles for this planning that the CDC developed, there was also an early effort to promote the distribution of HIV prevention resources to different populations based on greatest need.

In 1999 the CDC published a compendium of HIV Prevention Interventions with Evidence of Effectiveness in response to requests from prevention service providers, planners, and others who wished to implement science-based interventions that work. All of the interventions included in the compendium proved positive behavioral or health outcomes in scientifically based studies. The interventions, which are now known as Diffusion of Effective Behavioral Interventions (DEBIs), focus on four groups of individuals who were seen as being at risk for HIV, including MSM. These are primarily individual and group-level interventions, but also include community-level interventions. The DEBIs that specifically target MSM are: d-up: Defend Yourself; Many Men, Many Voices; and MPowerment.

Given that at least half of new HIV diagnoses occur among gay and bisexual men, it is critical that more DEBIs be developed targeting MSM subpopulations, such as older MSM, black MSM, Latino MSM, and others.
and heterosexuals, along with outbreaks of primary and secondary syphilis among MSM, led to concern that HIV incidence might once again be increasing. Until that point the CDC had mainly targeted its prevention efforts at people at risk for becoming infected with HIV (primary prevention) and provided funding to health departments and CBOs for programs aimed at reducing sexual and drug use risk behavior. The troubling new data and recommendations from community planning led the CDC to launch a new initiative, “Advancing HIV Prevention: New Strategies for a Changing Epidemic.” The initiative had four main components: make HIV testing a routine part of medical care; implement new models for diagnosing HIV infections outside medical settings; prevent new infections by working with persons diagnosed with HIV and their partners; and further decrease perinatal HIV transmission. This represented a fundamental shift toward the emphasis of secondary prevention in CDC’s overall HIV prevention strategy.

On September 16, 2008, the CDC provided testimony before a hearing of the United States House of Representatives Committee on Oversight and Government Reform, then chaired by Rep. Henry Waxman (D-CA). Testifying at this hearing were CDC Director Dr. Julie Gerberding and Dr. Kevin Fenton of the National Center for HIV/AIDS, Viral Hepatitis, STI and TB Prevention. At the request of Rep. Waxman, they submitted a sample budget that reflected their professional judgment of what it would take to change the course of the HIV epidemic in the United States. The two CDC leaders pointed out that an optimal HIV prevention program would require an additional $877 million in fiscal year 2009 and an additional $4.8 billion over five years, more than doubling the current budget. In her testimony Dr. Gerberding said, “CDC could greatly expand its efforts, increasing coverage and impact, and could provide leadership to an effective U.S. response to the epidemic at home... Not only do we need to expand what we know can work; we’ve got to find new things. The research for new tools is a very important part of it.” If funding were doubled, it was projected that it would be possible to reduce the number of people who do not know their HIV status by 50%, and cut the number of new infections in half over 12 years. Given the lifetime cost of treating a person with HIV, preventing just 4,800 new infections over

**CDC Policies and Programs, 2000–2009**

Starting in 2003 the CDC encouraged state and local health departments to use evidence-based approaches and required that directly funded community-based organizations (CBOs) implement one or more DEBs. CBOs were required to attend formal training on funded DEBI interventions and the CDC provided technical assistance through federally funded resources.

Also in 2003, the CDC began to prioritize HIV prevention efforts with persons with HIV and AIDS, a shift from an emphasis on primary prevention to secondary prevention. Increases in newly diagnosed HIV infections among MSM
five years would recoup all of the additional costs of the program.\textsuperscript{221}

In her conclusion, Dr. Gerberding stressed that “AIDS is a social disease as much as it is a viral disease. ... If we do not address the underpinnings of the problem [poverty, stigma, and homophobia] we are never going to be able to get where we need to be as a nation.”\textsuperscript{222}

**Current CDC HIV Prevention Programs**

**HIV Testing**
HIV testing has become easier, more accessible, and less invasive in recent years. The array of available HIV-test technologies has expanded and minimized the waiting period for receiving test results. Rapid testing allows clients to receive preliminary results the same day, which is useful in urgent medical circumstances and settings where clients tend not to return for HIV test results. The 2009 reauthorization of the Ryan White CARE Act included a goal of five million HIV tests annually through the Centers for Disease Control and Prevention and other federal programs.

For people who test positive, early detection and entry into care and treatment are critical steps in reducing the risk of HIV-related illness and death. Because medical treatment that lowers HIV viral load might also reduce risk for transmission to others,\textsuperscript{223} early referral to medical care can also prevent HIV transmission in communities. Likewise, testing presents an opportunity for those who test negative to get the education and support they need to stay negative.

However, according to a CDC estimate, about one in five people living with HIV is undiagnosed.\textsuperscript{224} Immigrants are more likely to test late and be diagnosed with HIV and AIDS concurrently.\textsuperscript{225, 226, 227} People who are unknowingly infected with HIV cannot take advantage of therapies that can keep them healthy and extend their lives, nor can they protect their sex or drug-use partners from becoming infected. Knowing whether one is positive or negative for HIV offers great benefits in healthy decision-making. As a key tool of HIV prevention, HIV testing must be available in a culturally sensitive manner to high-risk gay men and other MSM.

**STI Testing and Treatment**
It has been well documented since the early 1990s that people who are infected with an STI such as gonorrhea, syphilis, or herpes are
much more likely to acquire an HIV infection. If an HIV-infected person has an STI as well, their risk of infecting another person goes up dramatically. Experts cite at least two reasons for this connection, described below.228

*Increased susceptibility.* Intact skin is an excellent barrier against HIV. STIs such as syphilis and herpes that are characterized by lesions or ulcers on the genitals interrupt that barrier, creating a site for HIV to enter the blood and infect the individual. STIs that do not cause ulcers, such as chlamydia, increase susceptibility in another way: they stimulate the white blood cells of the immune system to concentrate in the genital area to help fight the STI. Increased concentration of white blood cells in the genitals means more cells vulnerable to HIV where it enters the body during sex, and therefore a greater chance of HIV infection.

*More infectious.* For reasons that are not quite clear, HIV-infected people who are also infected with STIs have higher concentrations of HIV in their genital fluids. For example, men who have HIV and gonorrhea are found to have significantly more HIV in their semen than HIV-infected men who are not also infected with gonorrhea. This increases the chance that HIV- and STI-infected men will infect sexual partners; more HIV in the genital fluid means a greater likelihood that HIV will enter a partner during sex.

Comprehensive STI prevention, education, and treatment programs can play a vital role in decreasing the sexual transmission of HIV, so STI prevention must be included in HIV prevention and education. Also, monitoring new STI infection rates can give an indication of which populations are primed for an increase in HIV infection rates. Finally, by combining HIV and STI prevention efforts, resources will be used in a...
more efficient manner and both epidemics will be better controlled.

**Individual- and Group-Level Interventions**

Individual-level interventions provide ongoing education, discourse, and risk-reduction counseling to assist people in making plans for individual behavior change and to provide them with ongoing support. These are provided in a one-on-one manner by educators and counselors. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV. Recent reviews of these interventions have demonstrated that, across studies, reductions in HIV risk behavior and improvements in knowledge, attitudes, and beliefs about HIV/AIDS were greater for the target populations who received the risk reduction intervention compared with those who did not. This is true for men who have sex with men, heterosexual adults, adolescents, and individuals receiving HIV prevention intervention delivered within drug treatment programs.

Group-level interventions also provide ongoing education, discourse, and risk-reduction counseling to assist people in making plans for individual behavior change. Within these programs the group dynamic offers the opportunity for peer education and support. The groups themselves promote and reinforce safer behaviors and provide opportunities for interpersonal skills training in negotiating and sustaining appropriate behavior change.

**Community-Level and Structural Interventions**

Community-level interventions (CLIs) are directed at a population rather than at individuals. The primary goal of CLIs is to improve quality of health by changing attitudes, norms, and practices through prevention marketing, community mobilization/organization, and community-wide events that promote healthy behaviors and work to change factors that negatively affect the health of a community’s residents, such as stigma and/or homophobia. Specific interventions include the distribution of influential behavior change messages, skills-building efforts, and the promotion of resiliency factors that exist within communities. Whatever its structure, a CLI achieves reduced health risks by changing group norms to improve or enhance the quality of health for the population.

Structural interventions address the social, economic, and environmental forces that directly affect the risk for HIV transmission. At the structural level, laws and policies that result in a lack of immigrant rights, LGBT discrimination, lack of family housing at migrant labor worksites, unregulated commercial sex, criminalization of possession of syringes, and lack of financial support for medical, educational, prevention, and social services can be changed through policy and legislative reform. For example, in 1992, New York State enacted a change in the public health law (Public Health Law 80.135) that carves out an exemption to the penal code regarding criminal possession of syringe equipment. The change in law gave the New York State Commissioner of Health the authority to grant waivers to CBOs and government entities to collect and furnish syringes. New York’s multicomponent syringe access and disposal program, informed by harm-reduction principles, has achieved a decline in HIV prevalence among IDUs from 54% to 13%. Structural-level changes buttress the gains in behavior change made through individually geared prevention interventions. HIV prevention efforts cannot succeed in the long term without addressing, through structural interventions, the social factors that underlie HIV vulnerability. We must continue to support and explore community-sensitive structural interventions that will complement behavior modification programs, as part of a larger, more comprehensive national HIV prevention program.
What CDC Could Do Differently to Better Prevent HIV Infections

In addition to the standard intervention approaches outlined earlier in this paper, HIV prevention with gay men and other MSM requires a range of innovative interventions that respond to the actual lives, communities, and norms of gay men and other MSM. This section will present recommended approaches and include examples from the experience of GMHC.

Social Marketing

A commercial marketer looks for ways to convince customers to purchase a product. Similarly, a social marketer tries to influence the behavior of a target audience. Social marketing takes commercial marketing technologies and applies them to “the analysis, planning, execution, and evaluation of programs designed to influence voluntary behavior of target audiences in order to improve their personal welfare and that of society.”

Research shows that many behaviors are developed and practiced among social networks within a shared value system, so social marketing can be effective in motivating behavior change and impacting norms within social structures. It can be used to influence the behavior of individuals or the behavior of policymakers and influential persons for policy and environmental changes.

Community Building

Those offering HIV prevention must carefully consider setting and context when they engage with the communities they serve. For prevention messages to reach the intended populations, they must be brought into the environments where those populations socialize and live.

Community events can effectively reach larger numbers of community members and can be staged in a variety of engaging ways. Such events develop community connectedness which, as we have seen, is an important factor in condom use among high-risk gay men. Community events allow for multifaceted approaches that engage audiences through activities, presentations, artwork, performances, and social marketing. They offer opportunities to distribute safer-sex kits and educational materials and provide HIV testing and linkages to services, as well as to gather evaluation data through surveys and questionnaires. Community events are a key component in reaching high-risk populations.

Internet Interventions

The Internet has become a remarkable social networking tool; people who once were unlikely to meet in the physical world are now only a few key strokes away from each other. It is not surprising that many persons with access to the Internet have used it to find love and companionship and, for many who engage in risk-taking behaviors, to find sex alone. Gay men

MySpace

Social networking sites offer access to groups of young people who are hard to reach outside the Internet, such as the House and Ball community, a predominantly black, gay culture. As part of GMHC’s Community PROMISE intervention targeting this community, GMHC created a MySpace page. The page showcased the work of the intervention and posted role-model stories, which were shared with all the “friends” who had connected with the Community PROMISE page.

GMHC and other prevention programs have successfully used such social networking sites to reach specific populations of high-risk individuals. When more resources are available, prevention programs can develop dedicated websites in a variety of modalities— informational, interactive, entertaining—to address specific audiences or specific issues that affect high-risk groups. Examples of these are sites that raise awareness around crystal meth, that showcase HIV prevention videos, and that address the topic of HIV stigma.
and MSM, whose sexual activities traditionally have been stigmatized, have benefited from the privacy of the Internet; half a decade ago, 40% of gay men reported that they use the Internet to find sexual partners. This number has likely increased since and will continue to increase in coming years.

The Internet is a powerful medium for HIV prevention efforts. Online outreach to gay men and MSM is an effective way to disseminate safer-sex messages, HIV prevention information, and referrals to HIV testing and services. Contact with individuals through online outreach takes place in public chat rooms and forums, as well as through other, more private Internet communication, including one-to-one “instant messaging” and email postings. Online outreach workers can engage individuals in conversations around safer sex, harm reduction, testing, and volunteer opportunities, as well as provide referrals when appropriate.

**Post-Exposure Prophylaxis (PEP)**

HIV post-exposure prophylaxis (PEP) is the start of antiretroviral HIV drug therapy immediately after a suspected high-risk exposure to HIV. The use of PEP is intended to decrease, but is not expected to eliminate, the possibility of HIV infection from the potential HIV exposure. PEP is a preventative medication (or series of medications) administered within 72 hours (and no more than 72 hours) following a high-risk exposure.

As such, PEP is recommended only for high-risk exposures to HIV that have occurred within the previous 72 hours. PEP was originally issued when a high-risk exposure occurred only in an occupational setting, such as to a health care worker accidentally stuck by a needle used for giving an injection or starting an intravenous line in a person living with HIV.

In January 2005, the CDC issued recommendations regarding the use of PEP. The 28-page document provides extensive data on the rationale behind using PEP, as well as guidance for those who might best benefit from the intervention. Examples of non-occupational high-risk exposures include:

- insertive or receptive unprotected vaginal or anal sex (without a condom or with a torn condom) with an HIV-positive partner, or with someone of unknown HIV status
- being stuck with a used syringe, accidentally or on purpose
- sharing needles or other injection drug equipment
- being a victim of a sexual assault
- sharing sex toys that have not been cleaned between uses
- contact of non-intact skin (open cut or wound) or mucus membrane (eyes, nose, mouth, etc.) with blood

A person concerned about possible exposure to HIV in a non-occupational setting (within the

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**MyBallroomLife.com**

MyBallroomLife.com is an exciting website created for the House and Ball scene to empower and raise awareness of HIV/AIDS among community members in an entertaining, interactive, and stylish way. In addition to HIV information and a resource guide, this site contains a message board, a video showcase, a ballroom history section, and a spotlight page containing personal testimonials. In the two video projects on the site, “The Luna Show” and “The Living in Leadership Show,” site visitors can see a variety of interviews with prominent figures of the scene and keep up to date with current events and relevant topics.
previous 72 hours) must first seek medical care and complete an exposure risk assessment with a health care provider to determine if PEP is an appropriate and viable option. Each individual assessment looks at the estimated level of risk for HIV infection (based on the mode of exposure) and any contributing factors.

The estimated risk of HIV transmission for insertive versus receptive anal sex is not the same. Findings from a study conducted in 1999 by Vittinghoff et al., which sampled a cohort of 2,189 high-risk homosexual and bisexual men to determine the per-contact risk of acquiring HIV infection from specific sexual acts, revealed that during anal sex the receptive partner was at higher risk for HIV infection than the insertive partner. Vittinghoff et al. estimated that per-contact risk of acquiring HIV from unprotected receptive anal intercourse was 0.82% when the partner was known to be HIV-positive and 0.27% when the partner was of unknown serostatus. Per-contact risk of acquiring HIV from protected receptive anal intercourse was estimated at 0.18% for both a known HIV-positive partner and for a partner of unknown serostatus. Additionally, per-contact risk associated with unprotected insertive anal sex was estimated at 0.06% and at 0.04% for protected insertive anal sex with either an HIV-positive partner or unknown serostatus partner. However, these estimates are not absolute. Each episode of potential exposure to HIV carries its own unique transmission risk depending on the nature of the exposure, the infectivity of the source, and host susceptibility. Cofactors that increase the likelihood of HIV transmission are high viral load and the presence of STIs.

PEP therapy consists of a 28-day course of two or three different types of antiretroviral drugs, such as zidovudine, lamivudine, and nelfinavir. Physicians generally prescribe an AZT + 3TC (Combidir) or FTC + tenofovir (Truvada) combination, because the drugs are coformulated to include two drugs and are easy to use. As with most antiretrovirals, these can cause side effects such as diarrhea, headaches, nausea/vomiting, and fatigue. Some of these side effects can be quite severe, and it is estimated that one in five people give up PEP treatment before completion.

Some people's insurance will cover the cost of PEP and related lab tests. Because PEP is considered experimental, a person's ability to access it may vary dramatically. The kinds of factors that might influence a provider's willingness to prescribe PEP include their knowledge about HIV and their comfort level in prescribing and monitoring the effects of anti-HIV medication. The cost of 28-day nPEP regimens range from $300–$1,800, depending on the regimen, not including costs for lab work and follow-up visits to the doctor.

**Pre-Exposure Prophylaxis (PrEP)**

Pre-exposure prophylaxis (PrEP) is an experimental prevention strategy in which HIV-seronegative individuals take antiretroviral HIV drugs prior to a possible HIV exposure and continually throughout periods of risk, to reduce that individual's risk of HIV infection. Researchers are considering the ongoing, daily use of such prophylaxis as a promising approach for people who engage in activity with high risk of exposure to HIV.

To date, PrEP has not yet proven effective.

As part of its commitment to developing new HIV prevention strategies, the CDC is sponsoring three clinical trials of PrEP and is participating in a University of Washington–sponsored trial in Kenya and Uganda. These trials will test the preventative effectiveness of the antiretroviral drug tenofovir disoproxil fumarate (or tenofovir, brand name Viread), used alone or in combination with emtricitabine (together, known as the brand name Truvada).

The CDC-sponsored trials are designed to answer important questions about the safety and efficacy of a tenofovir or tenofovir plus emtricitabine pill taken as a daily oral HIV preventative among three populations at high risk for infection: 1,200 heterosexuals in Botswana, 2,400 injection-drug users in Thailand, and 400 MSM in the United States (in Atlanta, Boston, and San Francisco). Results from these trials are expected in summer 2010.

Along with the CDC’s clinical studies, the National Institutes of Health (NIH) is currently supporting a study of 1,400 MSM in Peru and Ecuador to answer how effective and how cost-effective PrEP programs might prove to be. One mathematical modeling study found that PrEP would be cost-effective as long as it proved more than 50% effective.
As effective as it may prove to be, this strategy is not intended as an alternative to condom use or other proven HIV prevention methods. PrEP is unlikely to cause behavioral disinhibition, however, based on current research on post-exposure prophylaxis and preventive vaccines. These are both strategies in which disinhibition was considered to be a major danger, but high-risk behavior has not been shown to markedly increase in these studies.248

Based on current incidence rates, 19,510 new HIV infections are expected to occur among all MSM in New York City in the years leading up to 2013.249 A PrEP program targeting 25% of the highest-risk groups in New York City could potentially prevent between 4% and 23% of new infections, according to a modeling study reported in AIDS.250 Over half of these infections would be prevented in men who do not themselves take PrEP, due to reduced overall HIV prevalence. The cost was estimated at $31,970 per quality-adjusted year of life saved. 251

Rectal Microbicides

Around the world, almost all anal sex is unprotected. Unprotected anal sex is more likely than unprotected vaginal sex to transmit HIV, due to the more fragile lining of the rectum.252 During anal sex this lining may rupture, allowing HIV to enter the blood stream.

Rectal microbicides are a potential HIV prevention method in the early stages of development that would allow men and women to topically apply a gel, cream, or enema with anti-HIV agents prior to engaging in anal sex. By 2008, a trial was completed testing a vaginally formulated ARV-based microbicide for safety in rectal use. Results of the study showed that it was safe when used rectally; however, it was not effective in preventing HIV.

Three newly funded research projects will focus on rectal microbicide research in the coming years, to include efficacy in HIV prevention. Two large programs will be based in the U.S. (funded by the National Institutes of Health) and another in Europe. The goal is to develop rectal-specific products that are safe, effective, acceptable, and accessible, with scientists and advocates hoping to launch Phase III efficacy trials within the next decade.

These results bolster the efforts of the International Rectal Microbicide Advocates (IRMA), a network with nearly 1,000 members from six continents. IRMA recently released a report253 that serves as an authoritative reference on current scientific developments and advocacy efforts in the area of rectal microbicide research. The report also describes key advocacy goals and strategies for advancing the science, and outlines the significant global challenges around human rights, homophobia, gender inequity, criminalization, stigma, and denial that must be addressed if rectal microbicides are to be accessible to those that need them.

IRMA is calling for an increase of annual global spending for rectal microbicide research by 40% between 2011 and 2014, and a six-fold increase between 2015 and 2020.254 Governments and foundations from Europe, Canada, Australia, and the United States should share in this critical investment in this desperately needed new prevention technology.

Serosorting, Strategic Positioning, and Seroadaptation

Serosorting is the process by which a person makes choices about sex partners based on HIV status. The practice has existed since the early years of the HIV/AIDS epidemic, when many HIV-negative people chose not to have sex with HIV-positive partners. As knowledge has increased and stigma has decreased over the intervening years, researchers have noted an upswing in HIV-positive serosorting; that is, growing numbers of HIV-positive people choose to date, develop relationships, and have sex only with partners of the same HIV-positive serostatus.

Serosorting can be an active or passive strategy. For example, an HIV-positive person who seeks a sex partner through online chat rooms or bulletin boards may actively select seropositive partners and/or disclose serostatus in a personal profile, allowing potential partners to serosort and thereby reducing the odds of connecting with individuals who may react unfavorably upon learning that a potential partner has HIV.

Along with serosorting, HIV-positive individuals are choosing specific roles and behaviors with their sexual partners based on serostatus, a practice researchers identify as strategic positioning. Some
studies report that HIV-positive gay and bisexual men are more likely to take a receptive role with HIV-negative partners during anal sex, as the virus is less likely to be transmitted from the receptive to the insertive partner.\textsuperscript{255}

**Concerns about Serosorting** Data suggest that serosorting may decrease the rate of new HIV infection because there is less unprotected sex between positive and negative partners. However, the effectiveness of a serosorting strategy for HIV prevention depends on the accuracy of individual serostatus disclosures. Serosorting increases the rate of unprotected sex, not the rate of safer sex, and countless studies have proven that STIs are more common in people who have unprotected sex. Whereas an HIV-positive and HIV-negative (serodiscordant) couple likely would use protection (e.g. condoms) to prevent infecting the negative partner, couples with two positive members use protection much less often, thereby increasing the incidence of STIs. This was borne out in San Francisco, which in 2006 reported an upswing in STIs but a decrease in HIV infection rates. San Francisco Department of Public Health officials and researchers proposed that whereas the increase in STIs indicated either static or increasing rates of unprotected sex, rates of HIV infection were holding steady due to a shift in the way individuals were selecting partners: people were actively choosing to partner with others of the same serostatus.\textsuperscript{256}

Another concern about serosorting that couples in which both partners are thought to be negative may not have considered the window of time between exposure and a positive HIV test. The body takes some time to produce enough antibodies for an HIV test to detect the antibodies to the virus. Therefore, if a test is done before there are enough antibodies to be detected, the result will be negative even though there is an HIV infection. Negative couples who do not take this fact into consideration may not use safer sex methods. In some cases this may result in new STI or HIV infections.\textsuperscript{257}

HIV dual infection, or superinfection, has emerged as a concern for HIV-positive people who practice serosorting in order to have unprotected sex. It is a common perception that once a person has become HIV-positive, he or she no longer needs to worry about HIV infection and is essentially free of major risks from unprotected sex with other HIV-positive individuals. However, health officials have cautioned that reinfection may occur with new, possibly drug-resistant strains of HIV, which can further weaken the immune system, hasten disease progression, and potentially limit treatment options.\textsuperscript{258}

**Seroadaptation** In 2006, the activist Olivier Jablonski and the sociologist Jean-Yves Le Talec of the University of Toulouse, France, introduced the concept of seroadaptation.\textsuperscript{259} Seroadaptation means adapting one’s own prevention strategies and sexual practices based on personal HIV status and the known status of a partner. In practice, an HIV-positive person may choose to have sex only with same-status persons (serosorting). This person may pay special attention to undetectable viral load and to possibly concurrent STIs. He or she may negotiate selected sexual-risk limiting practices, such as withdrawal (to minimize oral or anal contact with semen), and soft sex versus hard sex (soft sex being sex with the reduction of friction, force, or duration that can increase the risk of tearing of the vaginal or rectal lining and thus increase the risk of contact with blood). An HIV-negative person may also decide to “negotiate safety” with a regular HIV-negative partner and choose to have unprotected sex. On an individual level, none of these procedures are 100% safe, but in combination, seroadaptation on a national or global level may reduce HIV transmission. The level of risk depends on the context, the available biomedical information, and the presence or lack of a negotiation process between partners, regular as well as casual.

In both serosorting and seroadaptation, gay men try to act in relation to their serostatus. In the case of seroadaptation, they use this knowledge to adapt their prevention behavior, not only to select their partners. Selection of a partner is not an easy strategy: When one wants to have sex, one may prefer to engage in condomless practices rather than refuse unprotected sex, or, on the contrary, prefer to engage in protected practices if the partner asks for it.\textsuperscript{260} It is for this reason, that people using seroadaptation use different harm-reduction strategies in different situations, that Jablonski and Le Talec determined that studying seroadaptation...
Health officials have cautioned that reinfection may occur with new, possibly drug-resistant strains of HIV, which can further weaken the immune system, hasten disease progression, and potentially limit treatment options.

over serosorting will give researchers a more complete understanding of the epidemiological implications of these prevention strategies. Although additional research is needed, the San Francisco Department of Public Health is one entity that considers seroadaptation a demonstrated prevention method, recognizing that it encompasses a range of HIV-risk reduction strategies including serosorting, strategic positioning, and others.

**Commercial Sex Venues**

Commercial sex venues (CSVs) are establishments that charge an admission fee or request a donation to allow patrons to engage in sexual contact on the premises. CSVs include bathhouses, sex clubs, and sex parties; some venues are in fixed locations, others change location. Research demonstrates that gay men and other MSM who frequent these venues may be at high risk of acquiring or transmitting HIV and other STIs.261 These venues are therefore important sites for HIV/STI/harm reduction interventions.

CSVs have in fact been an important component of HIV prevention interventions since the 1980s. Bathhouses, in particular, have long provided opportunities for sustained outreach efforts and for delivery of safer sex packets, educational materials, and referrals to venue patron. The kinds of interventions that occur at commercial sex venues have expanded in recent years, and staff at many CSVs now receive training on topics including HIV, STIs, substance use, and harm reduction so prevention information can be shared with venue patrons around the clock. Some CSVs now offer HIV testing on the premises. On-site HIV prevention outreach teams are not always possible, but bathhouses and other CSVs often display sex-positive social marketing materials, such as posters with messages about condom use, safer sex, HIV testing, and substance use, for a constant HIV prevention presence.

Such HIV and STI prevention interventions tailored to MSM who frequent CSVs are of an immediate priority to control the rising HIV and syphilis epidemics in this population. Recent research indicates that these on-site intervention efforts can be effective: Initial results of a pilot outreach and testing program conducted in California in 2006 indicated that more than 80% of men who participated in the study returned for a three-month follow-up with a counselor, and that over 70% of the men returned for their HIV testing results.262 At the three-month follow-up

- men who participated in the testing/ counseling were more likely to report communication with their partners about HIV,
- the number of men who had engaged in unprotected sex decreased, and
- the number of sexual activities under the influence of alcohol or drugs decreased.263

**Effective Prevention in CSVs: New York City**
The New York State Sanitary Code prohibits any penetrative sexual activity—oral, anal, or
vaginal—in commercial establishments (section 24-2.2). Although the New York City DOHMH has some reasonable concerns about unsafe sex occurring in these establishments, a zero-tolerance approach in enforcing the Code has been ineffective in stemming the rising rates of HIV and other STIs in patrons who frequent CSVs. Shutting down CSVs prevents community organizations and health advocates from doing effective prevention work and outreach at these venues. Moreover, closing venues will not curb unsafe sex; it will just change the locations in which it occurs, reducing opportunities for patrons to access HIV/STI testing and substance abuse counseling and referrals. When commercial spaces are not available, men turn to other venues, particularly private parties, which operate under the radar of health outreach.

For these reasons, closing these venues may, in fact, exacerbate the syndemics of HIV, STIs, and drug use, an outcome in direct contrast to the Code’s original intent as a prevention effort when it was implemented in 1985 at the onset of the AIDS epidemic. The New York State Sanitary Code, like similar codes in communities across the U.S., is now in sore need of revision.

GMHC’s response to the Code’s challenge to effective prevention can serve as a model for other communities. GMHC recommends that the New York State Sanitary Code be amended to categorize CSVs as a particular type of business and that the Code be revised so that prohibitions are directed specifically towards unprotected sexual activity. In the event that such an amendment is not made, GMHC recommends that the New York State Public Health Council grant exemptions from the Sanitary Code provisions to venues that agree to collaborate with community-based HIV/AIDS service providers in promoting only safer sex and offering prevention services. Venues that make such a commitment (codified in a Memorandum of Understanding or some other legally enforceable document), to collaborate with CBOs to prevent unsafe sex and promote safer sex, and that agree to on-site provision of services, would receive a waiver from enforcement actions. The advantage of this approach is that it would not require changing state law.

Working with CSVs throughout the country to provide HIV prevention to gay men and other MSM continues to present a variety of challenges. These are based in local regulations and laws around public sex, which must be considered on a case-by-case basis. However, CBOs, working in collaboration with local health departments and CSVs, are playing important roles in helping to shape the development and enforcement of important legislation. With such collaborative efforts, we can succeed in establishing environments in which otherwise hard-to-reach individuals can receive crucial HIV and STI information, direct access to services, and referrals.

**Comprehensive Sex Education in U.S. Schools**

HIV education as part of age-appropriate sex education in secondary schools is critical to preventing HIV infection among youth. The CDC’s incidence data for 2006 revealed the following figures regarding new infections among American adolescents and young adults:

- Adolescents and young adults (ages 13–29) comprised more than a third of newly diagnosed HIV-positive individuals, the age group most affected by HIV.264
- African-American young adults accounted for 60% of all new HIV infections among 13–24-year-olds.265
- 80% of the new HIV infections in adolescents and young adults ages 13–29 were diagnosed in gay men and other MSM.266

In spite of these figures, the CDC found that only 16% of young adults reported testing for HIV in 2006.267

These figures are even more alarming when one focuses on young adult sexuality. The Washington Post reports that after a steady decrease in reported teenage sex during the 1990s, the CDC’s Youth Risk Behavior Survey (YRBS) reported no change since 2001 among all races and ethnic groups.268 In fact, the YRBS revealed that almost half (48%) of all high school students reported having sex in 2007.269 However, close to one quarter (18%) of sexually active youth reported not using prevention methods for STIs or pregnancy the first time they had sex.270 African American and Latino students report having more sex than their white peers. They also report their first sexual experience at a younger age, with 16% of blacks and 8% of Latino students initiating sex before the
age of 13, compared to 4% of their white peers.\textsuperscript{271} Nearly one quarter of high school students who have sex reported drinking alcohol or using drugs the last time they had sex, which impairs their ability to make safer sex decisions.\textsuperscript{272} The fact that teenage sex is no longer decreasing among middle and high school students coincides with increased federal spending on abstinence-only-until-marriage education, which denies the needs of sexually active youth in the U.S. Abstinence-only sexuality education teaches that having sex before or outside the context of heterosexual marriage is wrong and harmful to young people and uses virginity pledges to discourage youth from having sex.\textsuperscript{273} Students are often asked to vow in front of their families, friends, or classmates that they will remain abstinent until marriage. Of course, by “marriage,” abstinence pledges mean heterosexual marriage only, thereby ignoring LGBT youth. Furthermore, social science research has found that young people taking virginity pledges were one-third less likely to use contraception when they did become sexually active than their peers who had not pledged.\textsuperscript{274} Research has also found that communities with a higher proportion of virginity pledgers reported significantly higher overall STI rates than in other settings.\textsuperscript{275}

According to the Sexuality Information and Education Council of the United States (SIECUS), the single most consistent predictor of condom use is positive attitudes towards condoms.\textsuperscript{276} Abstinence-only education prohibits educators from teaching about STI and pregnancy prevention unless the lesson emphasizes condom failure rates.\textsuperscript{277} Abstinence teachings are inaccurate. One abstinence-only education leader guide states that “condoms provide no proven reduction in protection against chlamydia, the most common bacterial STI.”\textsuperscript{278} In fact, when used correctly, condoms do reduce the risk of STIs, including chlamydia and HIV. Another curriculum claims falsely that “in heterosexual sex, condoms fail to prevent HIV approximately 31 percent of the time.”\textsuperscript{279} In fact, when used correctly, condoms are highly protective against STIs.

More false claims made by abstinence-only curricula are noted below:

- “At the least, the chances of getting pregnant with a condom are 1 out of 6.”\textsuperscript{280} (When used correctly, condoms are 98% effective in contraception.)
- “Condoms provide no proven reduction in protection against chlamydia, the most common bacterial STI”\textsuperscript{281} (When used consistently and correctly, condoms greatly reduce the risk of STIs, including chlamydia.)
- Touching another person’s genitals “can result in pregnancy.”\textsuperscript{282}
- Tears and sweat are included in a column titled “At Risk for HIV Transmission.”\textsuperscript{283} (The CDC states that “contact with saliva, tears, or sweat has never been shown to result in transmission of HIV.”\textsuperscript{284})

Abstinence-only education largely ignores homosexuality, except to define HIV as a homosexual disease. Sex Respect teaches students that “research and common sense tell us the best ways to avoid AIDS are: remain a virgin until marriage...and avoid homosexual behavior.”\textsuperscript{285} If youth incorrectly learn that HIV is only something gay people need to worry about, then educators risk adding to the already pervasive sense of immortality among youth who do not identify as gay. Youth who may currently believe “this will not happen to me” are given incorrect information from their teachers about the risks involved with heterosexual sex.

Many abstinence-only curricula spread false anti-gay stereotypes, as well as regressive gender stereotypes. Anti-gay bigotry is promoted in such damaging language and false claims as the following:

- “Many homosexual activists are frustrated and desperate over their own situation and those of loved ones. Many are dying, in part, due to ignorance. Educators who struggle to overcome ignorance and instill self mastery in their students will inevitably lead them to recognize that some people with AIDS are now suffering because of the choices they made.”\textsuperscript{286}
• “Among Kinsey’s most outrageous and damaging claims are the beliefs that pedophilia, homosexuality, incest, and adult-child sex are normal.”

In language promoting regressive, sexist gender stereotypes, boys are presented as sex-crazed; girls as less interested in sex than in finding love. And girls are given the primary responsibility of managing the sexual predations of boys. For example:

• “Watch what you wear. If you don’t aim to please, don’t aim to tease.”
• “Woman gauge their happiness and judge their success by their relationships. Men’s happiness and success hinge on their accomplishments.”

• “Guys are able to focus better on one activity at a time and may not connect feelings with actions. Girls access both sides of the brain at once, so they often experience feelings and emotions as part of every situation.”

Several states currently ban the positive portrayals of homosexuality in schools. As we have seen, family acceptance and school-based interventions are key resiliency factors for LGB youth. Studies have also shown that LGB youth who receive gay-sensitive HIV instruction in school tend to engage in risky sexual behavior less frequently than similar youth who do not receive such instruction. In a random sample of high school students and HIV education instructors in Massachusetts, among sexually active heterosexual and LGB adolescents, LGB adolescents had more sexual partners, used drugs and alcohol before sex more frequently, and had higher rates of pregnancy than their straight counterparts. However, the LGB youth who received gay-sensitive HIV instruction reported fewer sexual partners and less frequent substance use before sex than the LGB youth who did not receive such instruction.

Only 30% of U.S. voters believe that the federal government should fund sex education programs that have abstaining from sexual activity as their only purpose, according to SIECUS. However, the Bush-Cheney Administration decreased domestic HIV prevention by over $70 million from 2003 to 2006, while it increased annual funding for abstinence-only sexuality education by $176 million from 2001 to 2006. Many states have policies that mandate sex education in public schools. However, all the policies emphasize abstinence over contraception. For example, 23 states are required to stress abstinence as sex education compared to 14 states that are only required to cover contraception. Additionally, 35 states are required to provide STI/HIV education, but none are required to stress contraception. Of the 50 states, 26 states stress abstinence compared to 17 states that are only required to cover contraception as STI/HIV education. None of the 50 states are required to stress contraception as STI/HIV education.
Adolescents and young adults (ages 13–29) comprised more than a third of newly diagnosed HIV-positive individuals, the age group most affected by HIV.

Public opinion shows a desire for age-appropriate sex education that is inclusive of HIV education. According to SIECUS, 100% of parents of junior high school students and 98% of parents of high school students believe STI education is appropriate in a sex education program. They report similar levels of support for HIV education. Parents believe that sexuality education helps their children avoid STI and HIV infection, and adolescents and young adults themselves want this information. SIECUS reports that 82% of 15–17-year-olds and 75% of 18–24-year-olds want information on how to protect themselves from HIV and STIs. The same adolescents also want information on how to bring up sexual health issues such as STIs with partners.

During the past few years, states were choosing not to match federal Title V abstinence-only dollars, objecting to the federal programs being used in the state. Three federal funding streams for abstinence-only-until-marriage programming expired or were ended in 2009. Unfortunately, in a failed bid to win Republican votes, this program was reauthorized through health care reform in early 2010. GMHC and other public health advocates are closely monitoring this funding stream to ensure that any dollars are dedicated to effective, evidence-based programming; we will also work to defund abstinence-only programming for good.

What We Need to Do Differently

Fight Homophobia and Anti-Gay Bias as a Public Health Threat

Preventing HIV and STIs among gay men requires many more far-reaching initiatives beyond campaigns promoting safer sex and HIV testing. Although these are crucial in a complete approach toward eradicating HIV, we have seen in the previous discussions that disseminating interventions that confront social ills to a wide audience can have a profound positive impact on public health. Homophobia is one such social ill, and a pervasively anti-gay society erects barriers to community health, especially among minority groups and high-risk populations of color. Being hated and discriminated against for being gay creates many detrimental effects on gay men. When gay men are living with the shame, isolation and self-hatred encouraged by those around them, they may stop caring about themselves enough to want to engage in safer sex. Ron Stall’s syndemic theory (discussed more fully in the prior section, Sexual Identity and Behavior) can explain this phenomenon among urban gay men. When gay men suffer depression, anxiety and anger caused by being denied a job or promotion, being constantly harassed at school, or being rejected by family because of their sexual identity, they stop seeing themselves as worthy enough to aspire to loving relationships and supportive friendships, to maintain healthy habits, or to care enough about their sexual partners. In some extreme cases, homophobia and discrimination can lead to addiction, abuse, and violence. Increased rates of HIV infection are just one of the many public health costs.

We must counter homophobia, in all its expressions, subtle and overt, in order to make a
We must send a clear message to families that they play a critical role in promoting positive health outcomes among gay youth.

greater impact on HIV transmission. We urgently need meaningful interventions that speak to the love, acceptance, and connection that gay men seek day to day, interventions that look to shift society’s attitudes toward gay men, interventions that encourage support, generosity, and dialogue. Service providers should not be afraid to deal with these empowering issues directly as the foci of the interventions themselves. Whatever forms the interventions take—social marketing, support groups, or community events—HIV prevention must address these health-promoting factors head-on.

Promote Family Acceptance of Gay Youth

Family acceptance and support are integral to the positive development and overall wellness of all children, including young gay men. Parents who are intolerant of homosexuality and reject sons who come out as gay or bisexual do immeasurable harm to their children. We must send a clear message to families that they play a critical role in promoting positive health outcomes among gay youth.

Families who embrace their gay children should be visible in their communities in order to set positive examples, and gay youth who feel supported in their families should share their stories. Such publicity will promote the strengths and resiliency of families and encourage others to follow their leads. Local organizations should implement community-level interventions to disseminate and reinforce these messages, such as GMHC’s 2008 campaign “My Son Is My Life,” which presented the importance of parental support in the lives of black gay. The informational palm cards and ads in print media, distributed to reach both young men and their fathers, acknowledge the many reactions parents can have upon learning that their son is gay, and illustrate the steps parents can take to continue to provide support and love to their children.

To achieve fundamental change, we must challenge concepts of what constitutes a “normal” family in America. We must counsel families to let go of the heterosexist notion that all children will automatically be heterosexual, so that couples who plan to have children will consider the possibility of having a gay son. We must encourage families to let go of stigma and silence around homosexuality, so that parents who believe their son may be gay can find other families like theirs. Collaboration between HIV service agencies and groups that advocate for acceptance of gay youth, such as Parents, Families and Friends of Lesbians and Gays (PFLAG), serve extremely important functions in this regard.

To help us reach out to families, we must enlist the support of religious leaders, who have enormous impact on family values. While some religious leaders and organizations promote positive messages about LGBT people, many send messages of intolerance that influence family reactions to gay youth. Shifting to messages of love and acceptance will better the lives of gay youth and society as a whole.

Prevent HIV in Prison While Simultaneously Preventing Sexual Abuse and Rape

GMHC supports implementing STI/HIV education and prevention programs in prisons, including the distribution of condoms in prisons. By implementing such programs, we can help stop the spread of HIV, Hepatitis C and other STIs to other inmates, as well as to their spouses/partners and others with whom they come into contact after release. Sex education and condom availability should not be misconstrued to condone prison rape, which is epidemic in U.S. prisons.
Prisons put inmates at heightened risk for HIV when they fail to protect incarcerated persons from rape. Ending prison rape is necessary to ensure the health and safety of incarcerated persons. Incarceration and associated risk of rape is one element of a complex system which puts formerly and currently incarcerated persons and their communities at heightened risk for HIV. Inmates confined in state and federal prisons have AIDS at five times (.5%) and HIV at four times (2.3 to 2.98%) that of the U.S. population.304

Prisoners who are gay, transgender, or perceived to be gay or gender nonconforming, are at high risk of sexual abuse in prison. In male facilities, gay men, particularly those exhibiting stereotypically “effeminate” characteristics, and transgender women are extremely vulnerable to sexual abuse.305,306 One study, for example, found that 41% of gay men were sexually assaulted in prison, as opposed to 9% of heterosexual men.307 This same study found that 53% of a sample of 80 self-identified homosexual prisoners in a medium-security California prison had experienced sexual harassment and/or threats.308 Many male inmates consent to sexual acts against their will to avoid violence, apparently feeling there are no other options.309

Victims of rape in prison face many barriers to reporting their abuse. Many of those subjected to such abuse are reluctant to report their experiences, fearing retaliation by both prisoners and staff, and having justifiably little faith in receiving the appropriate relief. Those who report rapes are often not believed or told that they consented. They are often accused of being gay, the implication being that if they were gay they wanted it.310 When prisoners known to be gay or transgender report prison rape they are often told that they enjoyed the act, and that it was consensual. Others have reported that if they do not have physical evidence of an attack (e.g. wounds, scratches), their claims are not believed and considered unsubstantiated by prison authorities. Prisoners who report rape are not protected from other inmates, who may retaliate against the prisoner for being a “snitch.”311,312

To protect incarcerated persons from HIV, we must take significant steps to eliminate prison rape and support those inmates most vulnerable to sexual violence in prison.

There is a long-overdue response to sexual abuse of individuals in adult prisons and jails, immigration detention, lock-ups, community corrections, and juvenile facilities, especially among gay and bisexual men and those perceived to be gay. National standards are urgently needed to address the ways in which our current prison system heightens the risk of HIV for incarcerated persons, and bolsters the epidemic in the communities to which they return. GMHC supports the standards recently developed by the National Prison Rape Elimination Commission and urges the Department of Justice to adopt them.

Make Mental Health and Substance Use Services More Accessible

In order for gay and bisexual men to decrease their risk for HIV infection and in order to assure that men who are HIV infected are in care, it is essential that they have easily accessible mental health and substance use services. As we have seen, complex combinations of individual, sociocultural, and biomedical factors affect HIV risk behavior among gay men and other MSM. Factors such as childhood sexual abuse, substance use, depression, and partner violence have been shown to increase risky sexual behaviors; simply growing up gay in a climate of stigma and intolerance has myriad detrimental consequences. The combined effects of these problems may be greater than their individual effects.313 Mental health services for gay and bisexual men are essential.

The use of alcohol and other drugs by gay men can easily move from casual use to problem use, including addiction. This can cause serious physical and mental health risks. Substance use counseling, education, and treatment that address drug and alcohol use from a harm-reduction perspective should be made widely available to gay and bisexual men. In addition, HIV-positive and high-risk HIV-negative gay men who use alcohol and drugs should be able to access short-term substance use services, such as one-on-one and group counseling. Such services should offer a supportive environment for individuals to identify goals and to explore contextual factors of their use, in order to change their drug use and understand its relationship to their sexual behaviors.
For those for whom substance use has progressed to abuse and addiction, substance use treatment may require inpatient or ongoing outpatient care. Such individuals may require services such as addiction treatment programs, including residential treatment centers, outpatient treatment programs, and hospital inpatient programs for drug addiction and alcoholism. Few of these programs are specifically geared toward serving gay men or MSM. Organizations, programs, and services that help people confront serious substance use must be educated about and sensitive to the specific needs of gay men.

Discrimination by insurance companies and treatment facilities can pose obstacles to substance use treatment. Some insurance companies have refused to pay for such services. Crystal meth addiction in particular requires inpatient treatment for at least one month, and ideally six months or more. State regulators should encourage insurance companies to cover this medically necessary treatment.

Many detox facilities and treatment centers have recently refused to accept people with a history of MRSA, a dangerous form of staph infection transmitted primarily through sexual contact that has been seen in higher rates in gay men with multiple partners, meth users, and those with compromised immune systems. This means that people living with HIV/AIDS and gay or bisexual men are more likely to have a history of MRSA. There is no public health reason why someone with a history of MRSA, who has received treatment for the condition, should not be able to go into detox or access other forms of substance use treatment. In order to prevent discrimination and inappropriate treatment of gay men who had MRSA in the past, states should engage in cultural competency training with providers, and they should adopt regulations if training is not sufficient to end abuses.

Implement a National AIDS Strategy

GMHC has called for the development of a U.S. national AIDS strategy. Such a strategy has widespread bipartisan support in Congress and was regularly endorsed by President Obama and Vice President Biden during the 2008 presidential campaign. Numerous government and private studies have pointed to the need for better planning of U.S. HIV/AIDS policy and programming. For example, in 2004, the Institute of Medicine determined that federal financing of AIDS-related health care “does not allow for comprehensive and sustained access to quality HIV care” in the United States.³¹⁴
The U.S. HIV/AIDS epidemic requires a strategic plan of action that promotes coordination across agencies, levels of government, and social sectors; accountability; evidence-based policy; and a focus on improved prevention and treatment outcomes. A key priority should be reducing the striking disparities affecting black women and gay men, as well as, immigrants, Latinos, and Native Americans. Furthermore, the disproportionate impact of HIV on gay and bisexual men of all races (who represented nearly three in five new infections in 2006) must be addressed. The U.S. requires a national AIDS strategy of countries that receive assistance through the President’s Emergency Plan for AIDS Relief (PEPFAR), yet since 1981 the U.S. has not had one itself.

Over the past decade we have made significant strides in fighting AIDS in Africa and elsewhere overseas. Yet here at home the epidemic is worse than we thought. Forty percent more people get HIV each year than was previously known. Black women are 20 times as likely as white women to get HIV, and gay or bisexual men are at least 40 times as likely as the average person to get infected. Black MSM, who represent about one quarter of one percent of the adult population, comprise approximately 20% of new HIV infections each year in the U.S. An effective national AIDS strategy would enlist faith communities, labor unions, business leaders, and others in the fight against HIV and AIDS. It would prioritize gay men of all races, black women and men, and black gay men as priority populations.

Recent years have witnessed significant milestones in the development of a national AIDS strategy. In December 2007, Dr. Kevin Fenton, then director of the National Center for HIV/AIDS, Viral Hepatitis, STI, and TB Prevention, and other plenary speakers called for a national AIDS strategy at the biannual CDC HIV Prevention Conference. In May 2008, GMHC and several partner organizations hosted the first-ever Congressional briefing on the need for a national AIDS strategy. GMHC and our partners led numerous workshops at various national and international conferences to raise the issue’s profile. Presidential candidates Barack Obama, John McCain, and others endorsed the call for the development of a national AIDS strategy. Fiscal year 2009 (FY09) appropriation bills passed by House and Senate appropriations subcommittees included $1.4 million to the White House Office of National AIDS Policy (ONAP) to support meeting expenses, regional consultations, six full-time staff, and communications costs to develop and oversee the implementation of a national AIDS strategy. This funding was also approved in the FY10 federal budget, and the federal appropriations process will be closely monitored in the future to ensure ONAP is adequately resourced. The campaign received nationwide support; over 300 organizations endorsed the need for a national AIDS strategy. In 2009, ONAP convened more than a dozen community fora across the U.S. It has also convened meetings on women, youth, housing, and black men. As we release this report in mid-2010, ONAP is nearing release of a strategy.

It is critical that the disproportionate impact of HIV on gay and bisexual men of all races, and especially on black gay men, be a central element of any national AIDS strategy.
An Ethical Foundation for HIV Prevention

The dictionary defines an ethic as “a principle of right or good conduct; a system of moral values.” Since the beginning of the epidemic, HIV/AIDS stigma and discrimination have played a dominant role in defining the principal HIV prevention ethic. For the most part, “right or good conduct” has meant simply maintaining confidentiality in relation to a person’s HIV status and/or test results, with legal consequences for wrongful disclosure. However, this narrow ethical standard fails to shed light on a multitude of complex ethical issues facing policy makers, CBOs, researchers, HIV/AIDS advocates, and people living with HIV/AIDS, issues raised by the following public health practices:

• State-mandated HIV reporting;
• Mandatory HIV testing of selected population groups;
• Imposed requirements for HIV program participation (e.g., sobriety);
• Emphasis on HIV testing and case finding absent adequate access to medical resources;
• Emphasis on partner notification without adequate community-based resources and support;
• Criminalization of drug addiction;
• Criminalization of sex workers;
• Regulating commercial sex venues;
• Restricting condom and sterile syringe availability; and
• Abstinence-only-until-marriage programs.

Over the years, CBOs have struggled with these issues as funders have imposed greater restrictions on program content and implementation. In addition, CBO staff members are themselves influenced by personal and community values, which at times conflict with service delivery. For example, a staff member may work well with gay and bisexual men of color, but if a particular client is also a substance user, that same staff member may struggle with his or her own moral code formed by personal experience, judgment, beliefs, family history, and insufficient training.

An Expanded HIV-Prevention Ethic

The ethics surrounding HIV/AIDS are complex, as HIV spans multiple health, socioeconomic, political, and religious issues. This complexity will only increase and become more of a challenge as people living with HIV/AIDS continue to live longer, if stigma and discrimination continue to thrive and if public health institutions continue to bend to prevailing politics. Now, more than ever, it is vital that HIV/AIDS advocates, CBOs, researchers, and other stakeholders become deeply engaged in creating a common voice to ensure that those who are most vulnerable will not become the victims of institutional and political agendas in the name of “the public good.” Research has shown no public health advantage to adopting more prescriptive HIV-prevention program and policy approaches over other, more libertarian approaches. Public health practices advancing the public good while preserving personal liberties are effective because people are more likely to follow through with health-promoting behaviors (e.g., treatment, screening, safer sex, condom use, etc.) when they are self-motivated and given the freedom to do so on their own.

An open, active, engaged, and productive dialogue across ideologies and disciplines about various issues is a prerequisite to creating effective HIV prevention interventions targeting gay and bisexual men. The keystone of this dialogue is a shared view of fundamental ethical precepts that are still not yet widely embraced. The following are the precepts that GMHC believes form the basis for ethical approaches to HIV prevention:

• The imperative of reducing HIV infection rates should not impinge on personal freedom;
• All people with HIV deserve the same level of support, health care, and political rights as anyone else;
• All people, HIV-positive and HIV-negative, are entitled to a fulfilling and satisfying sex life; and
• Barring harm to others, all people, HIV-positive and HIV-negative, have the right to be self-determining.

Broader adoption of these precepts will provide a starting place for the development of effective HIV prevention interventions. Over time, they
must be fully integrated into all aspects of HIV prevention intervention design, delivery, and evaluation. The responsibility of ensuring that these ethical precepts remain at the foundation of an HIV/AIDS prevention agenda falls to everyone—community members, public health institutions, CBOs, researchers, and advocates.

All people with HIV deserve the same level of support, health care, and political rights as anyone else.
Recommendations to the Obama Administration and the 111th Congress

Presently, HIV prevention in the U.S. lacks the resources, comprehensiveness, and sustained approaches that will significantly drive down HIV incidence rates. The key to further reducing HIV incidence in the U.S. is in our capacity to more effectively target resources and stay focused on classic prevention principles. We must reexamine how we think about, plan, and implement HIV prevention policy, research, and practice.

In other health fields with much longer histories, prevention has a more sophisticated shape. For example, smoking prevention programs combine pharmacological interventions, behavior modification, social persuasion techniques (including the use of social marketing to influence community norms), and structural change (such as policy reform and legislative initiatives) designed to discourage nicotine use. In New York City these have taken the forms of high taxes on cigarettes and a ban on smoking in restaurants and bars. Nicotine addiction and HIV infection are different and we must exercise caution in comparing the two. But the comparison is compelling and raises important questions about some of the limitations of contemporary HIV prevention in the U.S. Imagine what a large-scale commitment to HIV prevention with gay men, including television advertising and structural interventions to decrease antigay prejudice, might look like.

Mainstream descriptions of the HIV/AIDS epidemic in the U.S. often paint an incomplete and misleading picture. These descriptions often start with statements about the disproportionate toll HIV/AIDS is taking in communities of color, especially among African Americans, with no mention of the specific subgroups most at risk, namely gay or bisexual men, drug users, and black and Latina women at sexual risk. Moreover, funding remains inadequately targeted to these groups. This is especially troubling when we consider, for example, that men who have sex with men continue to make up the majority of new HIV infections and the majority of people living with HIV/AIDS nationally, across race and ethnicity. Around the country, gay and bisexual men, and especially gay men of color, are most impacted by the AIDS epidemic.

The HIV/AIDS epidemic among gay men and other MSM demands a response that is proportionate, effective, comprehensive and sustained.
Recommendations to Decrease HIV Infection among Gay Men

HIV Testing
- HIV testing should be easily accessible and encouraged to all people, regardless of one’s perceived risk of infection.
- Health care professionals providing HIV testing services must be culturally sensitive to the issues facing gay and bisexual men.

HIV Prevention and Programming
- Governmental funding and support for HIV prevention programs that address the needs of gay and bisexual men must be at levels proportionate with the epidemiology of the HIV/AIDS epidemic.
- All programs that address the health and mental health needs of gay and bisexual men must be culturally sensitive to the life issues facing gay and bisexual men.
- Health and demographic surveys should gather data on sexual behavior, sexual orientation, and gender identity. Specifically, the CDC and state and local governments should track transgender women differently from gay and bisexual men.
- Prevention and treatment of drug and alcohol addiction must be central to HIV prevention efforts.
- Government support for individual and group-level interventions must increase. Evidence-based interventions must be developed for gay and bisexual men of color and older gay men of all races.
- HIV prevention approaches must incorporate existing individual and collective strengths and resources within individuals and communities.
- Government support through the CDC and other federal agencies to support community-level interventions must increase substantially to adequately meet the numbers of gay and bisexual men that must be reached. Specifically, these interventions need to include strength-based and affirming social marketing, community-building activities, and interventions reaching social networks through the Internet.
- Government support for biomedical approaches to HIV-prevention must be increased, specifically research regarding PrEP and PEP. Additionally, research into the efficacy of rectal microbicides for gay men must be expanded.
- Departments of health, the CDC, and CBOs should examine and replicate approaches to HIV prevention that have been developed by members of the gay community themselves, such as serosorting, strategic positioning, and seroadaptation.
- CBOs and health departments must reach gay men with HIV prevention materials at locations where risk behavior may take place, such as commercial sex venues.
- CBOs and health departments must reach gay men with HIV prevention materials where gay men meet and socialize, making use of social networks and the Internet.
- Up-to-date epidemiological science and technology should be used to guide local efforts in the development and implementation of HIV prevention strategies.
- Collaborative approaches to formulating effective HIV prevention interventions should be tailored to meet the specific needs of various MSM communities. Technical assistance and capacity building should be made available when and if requested.
- Prevention efforts should target all gay men at risk, including those 50 and older.
- The DOJ should adopt the standards recently

Government should support comprehensive, age-appropriate sex education in schools.
developed by the National Prison Rape Elimination Act.
• CDC and DOJ should expand HIV prevention education in prisons.

HIV Prevention for Youth
• Government should support comprehensive, age-appropriate sex education in schools. We especially urge the federal Department of Education to exhibit greater national leadership on this issue, in partnership with the CDC and local and state education and health departments. Nineteen million Americans get an STI each year—half of them 15 to 24 years old. This is an unacceptable public health failure.
• Government should support programs and services that promote family acceptance of gay and bisexual men. Departments of public health should fund social marketing campaigns aimed at increasing family acceptance of gay sons.
• Federal and state governments should support gay-affirming interventions and activities in schools such as gay-straight alliances.

Social and Economic
• Interpersonal, social, and cultural determinants of HIV risk must be addressed. Examples of these include poverty, financial dependence, powerlessness in relationships, stigma, homophobia, and pressure to conform to stereotypical gender norms.
• Federal and state laws and policies should be evaluated for their impact on the social, economic, and environmental forces that have been shown to directly affect the risk for HIV transmission, and changed if necessary.
• Disparities in access to health care experienced by gay and bisexual men must be eliminated.
• Stigma associated with HIV/AIDS, drug use and homosexuality must be eliminated.

2009 Gay Men’s Health Agenda
In addition to the recommendations above, GMHC helped to create and has endorsed the “2009 Gay Men’s Health Agenda” which includes eight recommendations to address the overall health of gay, bisexual, and transgender men. These recommendations are:

1. Fund and expand social, behavioral, and biomedical research.
2. Develop and fund data collection efforts on sexual orientation and gender identity in all federally funded research.
3. Fund campaigns to combat homophobia, biphobia, and transfobia.
4. Eliminate “No Promo Homo” policies (federal rules that do not allow the “promotion” of homosexual behavior).
5. Create an Office of LGBT Health as part of the U.S. Department of Health and Human Services.
6. Develop and implement a strategy to reduce health disparities among gay, bisexual, and transgender men through direct programmatic funding.
7. Implement and fund sexual health and wellness campaigns toward gay, bisexual and transgender men’s communities utilizing an array of public and private resources.
8. Develop and implement a strategy to remove barriers to health care among transgender people through legal changes and education of medical and health insurance professionals.

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...
Seventy-five percent of young men who have sex with men (YMSM) in Los Angeles and New York have engaged in serosorting, a process where individuals avoid sex with persons who have been tested positive for HIV. Serosorting is a broader concept and a more precise process model of risk-reducing sexual behavior often labeled as “serosorting.” The aim of this article is to provide a preliminary examination of the phenomenon of serosorting and to offer a demographic profile of YMSM who are engaging in this behavior. Serosorting may be considered an element of the multi-faceted HIV prevention strategy of sexual risk reduction. This paper highlights young men’s experiences on serosorting and highlights the need for increased research regarding the implications of serosorting for sexual health and HIV prevention efforts.

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GMHC is a not-for-profit, volunteer-supported and community-based organization committed to national leadership in the fight against AIDS.

GMHC fights to end the AIDS epidemic and uplift the lives of all affected.

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