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Prevention with HIV-positive men who have sex with men: regaining lost ground

Kevin A Fenton

The data are clear: the sexual health of gay, bisexual and other men who have sex with men (MSM) continues to deteriorate in many western industrialised countries. The epidemiological trends appear consistent: a resurgence of bacterial and viral sexually transmitted infections (STI); rising or stable HIV incidence; recent outbreaks of lymphogranuloma venereum and hepatitis C, especially among HIV-positive MSM; accompanied by a stable or increasing prevalence of risky sexual behaviours including unprotected anal intercourse, serodiscordant unprotected anal intercourse and high rates of partner change. These individual level changes are occurring within a wider context of evolving social, cultural and risk environments and norms and at a time when MSM in many developed country settings are enjoying unparalleled social acceptance and freedoms. Concomitant changes in the availability, use and abuse of recreational drugs, including alcohol, continue to fuel risk behaviour and drive disease incidence. Similarly, the growing population of HIV-infected MSM, many of whom are unaware of their HIV infection, may be increasing the burden of infection at a time when more men are reporting homosexual sexual behaviours and partnerships.

The reality is that in many developed countries, gay, bisexual and other MSM continue to bear the brunt of the HIV epidemic. In the USA, nearly 60% of incident HIV infections are among MSM (including MSM who inject drugs), and HIV incidence has been rising unabated within this group since the early 1990s. HIV diagnosis rates among MSM are now many times those of women and heterosexual men in the USA, with HIV prevalence among MSM ranging between 18% and 40% in some large metropolitan areas. There are now more than 500,000 gay, bisexual and other MSM living with HIV infection in the USA, including an ageing cohort of individuals living with co-morbidities. Similar trends are being observed in other parts of north America and western Europe, reflecting a collective failure to reduce HIV incidence, to expand the tool-kit of available culturally competent evidence-based interventions, to implement and bring to scale effective prevention interventions for gay, bisexual and other MSM, and to provide sustained and meaningful engagement of affected communities.

Regional and national trends reflect the realities, challenges and contexts of HIV prevention, treatment and care being provided at the local level. In their paper exploring STI and risky sexual behaviour among HIV-positive MSM, Mayer et al highlight some of the challenges facing secondary prevention with a cohort of urban, adult, educated HIV-positive MSM in care and the continued vulnerability of this population to poor sexual health outcomes. Although many of the patients in this cohort had been diagnosed and had been receiving treatment or care for nearly a decade, nearly one in 10 had been diagnosed with an STI in the past year, of which more than two-thirds were diagnosed with syphilis and a third with gonorrhoea. The majority of patients were currently on highly active antiretroviral therapy, yet only half had an undetectable viral load. The sample reported a relatively high prevalence of drug and alcohol use in the past 3 months, with nearly one in five reporting either binge drinking or crystal meth use. Half of the sample had engaged in transmission risk behaviour in the past 6 months, with this behaviour being associated with the length of time post-HIV diagnosis, the use of crystal meth, ketamine or inhalant and having a detectable viral load. The authors rightly conclude that the high rates of HIV and STI transmission risk behaviour in their study suggest that effective secondary HIV prevention intervention programmes, especially those targeted at younger or more recently diagnosed MSM, are an urgent priority. They call for innovative programmes that facilitate education and skills building around safer sex, and that integrate substance abuse and STI screening, treatment and referral options for HIV-infected MSM in care to improve the sexual health of MSM.

These data are sobering on many levels, and should inspire critical reflection on the current state of HIV prevention with gay, bisexual and other MSM. More specifically, the study by Mayer et al highlights broader deficiencies with secondary prevention for HIV-positive gay, bisexual and other MSM in three domains: defining the technical package of effective evidence-based secondary prevention interventions that should be delivered consistently and with high quality to all HIV-positive MSM in care; closing the implementation gap between what research has been shown to be effective and what actually gets put into practice; and sustaining comprehensive and integrated prevention activities within the context of the rapid scale-up of antiretroviral therapy.

Secondary prevention is a critical component of our comprehensive HIV prevention efforts for MSM, yet the implementation and scale-up of effective secondary prevention programmes remain deficient. In most developed countries, a substantial proportion of HIV-infected MSM are now aware of their HIV status and are likely to be in care. This provides regular and ongoing opportunities not only to assess, monitor and manage their clinical condition, but also to identify and address other health, psychosocial and support needs.

There is a range of secondary HIV prevention options available for individuals living with HIV that can be delivered in clinical as well as in non-clinical settings. However, we are still doing a relatively poor job of screening HIV-positive gay, bisexual and other MSM routinely and consistently for STI and recreational drug abuse, providing partner services, or ensuring appropriate referral services for drug treatment, mental health and other support services. The reasons for this are many and include restricted funding, lack of clear and supportive guidelines and policies, time limitations in the clinical interaction, lack of provider awareness and restrictive administrative requirements. However, a major impediment remains persistent confusion on defining...
the ‘technical package’ of prevention interventions that should be delivered to all HIV-positive gay, bisexual and other MSM in care (the ‘what, when, where, how and by whom’). For example, at minimum, a multicomponent strategy for preventing the sexual transmission of HIV among sexually active HIV-positive MSM could include: antiretroviral treatment; adherence counselling and support; STI diagnosis and treatment; partner testing and disclosure; condom distribution and provision and risk-reduction counselling (see Table 1). Defining the content and frequency of delivery such a technical package for HIV-positive MSM in care is important to ensure consistency in approach, clarify provider expectations, guide resource allocation and provide standards against which performance may be measured and held accountable. In its absence, we will continue to experience the long-standing inequities in coverage, comprehensiveness and quality of secondary preventive services provided to this population, and will do a disservice to our patients and the community.

Second, even when established evidence-based interventions exist, there is a tremendous implementation gap between what we know works and what gets implemented. Currently, only a small fraction of MSM in need of intensive intervention is being reached by existing mechanisms, reflecting a combination of deficiencies in funding, prioritisation, accountability and leadership at the local level. Closing this gap will require that implementers and decision-makers not only understand and define the technical package for secondary prevention with HIV-positive MSM, but also provide resources to support adequate dissemination, training, and implementation, implement strategies, including clinical audits or cohort reviews, to assess and improve quality and increase accountability and develop robust monitoring systems to provide ready insight and evidence for implementers and decision-makers.16 Whenever possible, secondary prevention activities for HIV-positive MSM must be integrated into treatment and care services, and they must enable more efficient access to interventions designed to meet a range of complex physical, social and mental health needs.

Understanding the determinants and trajectory of risk among this population might also be helpful in identifying which patients should be prioritised for intensive and sustained interventions and when best to do so. The data of Mayer et al14 suggest that particular attention needs to be paid to younger HIV-positive gay, bisexual and other MSM, those who have recently seroconverted, those with a history of reported drug use and those reporting ongoing risky sexual behaviour. Understanding when and why risk is likely to occur can also help to prioritise individuals who might benefit from closer follow-up or counselling, or have access to intensive partner counselling and referral services.

Finally, the data of Mayer et al14 are a powerful reminder of why prevention cannot, and does not, end with treatment of HIV-positive individuals. In contrast, sustained efforts are required to integrate prevention into HIV treatment and care services. Expanding HIV testing, promoting earlier treatment of HIV, maximising treatment adherence and achieving individual and community viral load suppression will be critical components for controlling HIV among MSM, and every effort must be made to scale up these effective biomedical interventions in the near term. However, even in the most comprehensive treatment and care settings, many HIV-positive individuals in care will not have undetectable viral loads and most will have ongoing transmission risk behaviours. When these behaviours occur within the context of highly prevalent STI and recreational drug abuse, the potential prevention gains made by highly active antiretroviral therapy may be offset. Scaling up HIV testing and treatment for MSM living with HIV infection are thus necessary, but may not be sufficient to reduce HIV and STI transmission within this community.17 Prevention must be integrated and sustained in clinical care for HIV-positive MSM, and should be complemented by concurrent prevention efforts targeting MSM in the community and wider society. These efforts should be aimed at reducing ongoing risk behaviours, promoting HIV health awareness and providing medical and psychosocial support as needed.

Nearly three decades into this pandemic, despite awareness that gay, bisexual and other MSM account for the majority of new HIV infections and disproportionate rates of HIV and STI in many developed countries, the prevention tool-kit of culturally competent, effective and integrated HIV/STI prevention interventions remains inadequate, and implementation in clinical settings is heterogeneous at best.18 The time is now right for us to reflect on how best to work with the community to find a new way forward. We cannot continue along the existing trajectory and a more radical rethink will be required to regain the lost ground with prevention for this population. Key to this will be working with communities, scaling up effective interventions, holding each other accountable and ensuring an ongoing commitment to develop and implement new and improved tools to meet the needs of gay and bisexual men today, tomorrow, and beyond.

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