Are Condoms Over?

Research and Reality for Gay Men

by Mark Milano

“Condoms are over. Everyone knows they don’t work for gay sex. If you use them, you’re naïve.”

“Condoms were for all the AIDS guys 30 years ago.”

“The reason there were so many more gay AIDS cases than straight ones in the ’80s and ’90s is that both gays and straights used condoms, but they broke much more for gay men.”

“There’s no point in using condoms because they will break 50% of the time. They’re more trouble than they’re worth.”

These are all direct quotes captured a few months ago by longtime gay activist Rebecca Reinhardt at a West Hollywood gathering of gay college alumni in their 20s and 30s.

I was disappointed but not shocked when she posted these quotes online. Since the steep decrease of in-person HIV education, gay men get almost all their info about safer sex online. It is perhaps due to this that misinformation about HIV transmission is something I regularly encounter in the workshops I give at ACRIA. For example, at a recent workshop on HIV prevention, one participant put oral sex without a condom in the highest risk category, even though it’s actually a very low-risk activity. Many similar statements have convinced me that we need to relaunch in-person or online interactive safer sex workshops, especially for gay men.

But where has the lack of faith in condoms come from? Since I began working as an HIV educator in the late ’80s, I have always taught that correct and consistent condom use was over 98% effective in preventing HIV transmission, based on CDC statements. Had I been wrong all those years? Is there really a big difference in the effectiveness of condoms for vaginal vs. anal sex? I decided to look at some of the claims and the data.
One of the first things I encountered was condom-bashing from PrEP advocates. Now, I think PrEP (taking Truvada to prevent HIV infection) is an important option and should be made available to all who need it. Regardless of how well condoms work, it’s clear that many gay men aren’t using them and that more prevention options are badly needed.

But do we need to bash condoms in order to promote PrEP? One PrEP advocate created a graph showing that PrEP was 99% effective but that, according to the CDC, condoms were only 70% effective. Really? The data I’ve seen on PrEP shows proven effectiveness of around 92% (the 99% number is a mathematical model that needs more research), and that was in studies in which people also used condoms. But since the 99% figure is being used everywhere, I can see why a gay man might abandon condoms for PrEP — who would take a 30% risk with condoms when a pill could lower it to 1%?

I also wonder what effect this could have on HIV-positive gay men. I recently asked my boyfriend, “When I told you 12 years ago that I had HIV, would you have kept seeing me if you thought that condoms were only 70% effective?” He said there was a strong chance he wouldn’t have. My reassurances that condoms would protect him allowed him to be with his first HIV-positive partner.

So if gay men become convinced that condoms offer only partial protection, will those who aren’t taking PrEP become afraid to have sex with poz guys? And if condoms fail so often, how has my boyfriend remained negative all these years without PrEP? We use a condom every time and haven’t had one break. Are we really that far outside the norm? Let’s take a look at the data.

The 70% Study
For years, most of the data around condom effectiveness came from studies of heterosexuals. In my workshops, I often cite a 1994 study by the European Study Group on Heterosexual Transmission of HIV. It found no HIV transmissions among 124 serodiscordant couples (one partner with HIV, one without) who reported using a condom every time. This was powerful evidence of the effectiveness of condoms, long before PrEP was available.

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But that was heterosexuals in 1994. What about gay men today? Do condoms offer the same level of protection for anal sex as for vaginal sex? To answer that question, Dawn Smith of the CDC did an analysis of two studies from the late ’90s of HIV-negative MSM (men who have sex with men). (The study includes this disclaimer: “The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the CDC.”)

Smith looked at 4,492 MSM enrolled in an HIV vaccine trial, VAX 004. In that study, 48% reported anal sex with an HIV-positive partner during the study, and 7% acquired HIV infection. She also looked at 3,233 MSM from Project EXPLORE, a behavioral intervention study. In that study, 41% reported anal sex with an HIV-positive partner, and 5% acquired the virus.

Smith estimated the effectiveness of condom use by looking at men who reported they “always used” condoms for anal sex with an HIV-positive partner to those who “never used” them. Smith was saying that even when people said they used condoms every time, they offered only 70% protection for anal sex. Since her study was well done and carried great weight, I arranged an interview to ask her to address how the results were being misinterpreted. Here are some quotes from our talk.

Do we need to bash condoms in order to promote PrEP? One PrEP advocate created a graph showing that PrEP was 99% effective but that, according to the CDC, condoms were only 70% effective. Really?

Dr. Smith, your study is being cited all over the web as “The CDC reports that using a condom every time for anal sex is only 70% effective.” Is that what you meant to say?

It is correct that in our analysis, when condoms were reported to be used 100% of the time for anal sex, they were 70% effective.

But when people report that they used a condom every time, is that always accurate or is there over-reporting?

There may be over-reporting or under-reporting. We don’t have a gold standard for condom use, so the best thing we can do is to ask people repeatedly over time about their condom use.

Some people are saying that your study says condoms fail 30% of the time.

That’s not what we said. This was not a study of condom failure. What we said is that if you compare people who report that they always use condoms for anal sex to people who report that they never use condoms, there are 70% fewer HIV infections among those who report they always used a condom. So our best estimate of condom effectiveness for anal sex is 70%.

But why do other studies of condom failure have rates that are so much lower?

Our study could include cases where the condom slipped or broke and the users were not aware of it. Nothing in life is 100%. It’s not surprising to me that we don’t find 100% protection from this or any other intervention.

I’m just trying to respond to people who say your study shows condom failure rates of 30%.

Then you’re talking to the wrong person. We never used the number 30%. If somebody out there is using that number, you need to talk to them about that. We said it was a 70% reduction in HIV incidence. You shouldn’t come up with another spin on what we said – you should use our language.

Condom Failure

I had hoped Dr. Smith would help me explain why her study was so different from what I had taught for years, but that didn’t happen. So I decided to look at the research again, this time focusing on studies of condom failure during anal sex. (“Condom failure” refers to how often the condom breaks or slips off during sex.) Could it be true that they fail much more continued on next page
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during anal sex than during vaginal sex? Here’s what I found.

A 2011 online survey of 944 men conducted by the Rollins School of Public Health found a condom failure rate for anal sex of 4.1%. A Dutch study of 671 gay men found a failure rate of 3.7%, but when people used them correctly (with a water-based lubricant), that number dropped to 1.7%.

A study from London’s City University looked at 283 gay male couples who had been randomly assigned to use either standard or thicker condoms for anal sex. Each couple was provided with nine condoms and completed a questionnaire after each sexual act. But the study found no real difference between the two types of condoms. When they were used correctly, the standard condoms failed 2.5% of the time and the thicker condoms 2.3%. It was the way they were used that determined whether they failed. The researchers recommended that gay men:

- Unroll the condom on the penis, not before putting it on.
- Use additional lubricant.
- Apply lubricant to the outside of the condom only.
- Apply lubricant in and around the anus.

The authors also noted:

Previous studies have consistently reported that some men report frequent incidents of condom failure whereas others report never having experienced failure at all…. Behaviors associated with condom failure include a history of failure, the infrequent use of condoms, engaging in anal rather than vaginal intercourse, not using lubricant consistently, the use of inappropriate (not water-based) lubricant, and the age of the condom used.

In fact, Dr. Smith’s analysis found a large difference between the two studies it included. While the behavioral intervention study showed that condoms were 86% effective, the vaccine study found they were only 61% effective. Why the large difference? Is it possible that men in the behavioral study learned better condom skills over time?

Whatever the reason, the take-away message is that condoms seldom fail during anal sex if they are used correctly. Avoiding air bubbles, unrolling the condom on the penis (not before putting it on), and using a lot of the right (water-based) lubricant are especially critical if condoms are to protect during anal sex. Once you learn how, it’s simple to use them correctly.

Self-Reporting

The studies on condom failure I found confirmed that the number I’d been using for years was right: when used correctly, condoms work close to 98% of the time, even for anal sex. So why was Smith’s study so different?

I decided to look at self-reporting. As Dr. Smith reported, the studies she analyzed asked people if they used condoms “always”, “sometimes”, or “never”. Was it possible that people weren’t being entirely honest, or misremembering how often they used condoms? As someone who’s taken part in several studies that asked specific details about my sex life, I know how hard it is to be honest when an interviewer is asking very intimate questions. Shame, embarrassment, and wishful thinking can definitely influence your answers.

And in fact, studies have found this to be the case. A 1995 study found that self-reported condom use was not associated with lower rates of STDs. A 2003 microbicidal study stated:

Although most women believed they were accurate in their answers about condom use, a number of women admitted to exaggerating their condom use or believed other women did, citing concerns related to interviewers’ expectations of them as the primary reason.

A 2008 study of 186 young women who reported consistent condom use found that 34% of them actually had sperm in their vaginal fluid. A 2010 study looked at 11 surveys of female sex workers and MSM from five Central American countries and the Dominican Republic. People who reported always using condoms were asked to think again about the specified time period, and to confirm that there was no instance in that time period when a condom had not been used. The researchers found that in all the surveys, the number of people reporting consistent condom use decreased after follow-up questions were asked. Among MSM, the difference in self-reported condom use dropped as much as 37%. In one of the surveys, the number of MSM who reported using a condom every time dropped from 89% to 52% after re-questioning. The authors concluded:

Given the amount of recall bias and social desirability bias usually associated with

“High failure rates in some studies occur because many people over-report contraceptive use to shift the responsibility to a ‘faulty’ contraceptive. Such over-reporting artificially inflates failure rates.”
have been shown to inaccurately report condom uses, use condoms incorrectly, and respond to survey questions with what they perceive to be socially desirable answers (Rose, 2009). In fact, most people who use condoms do not experience breakage or slippage. Most condom failures occur among a minority of users because they are less experienced and/or less careful about using condoms than more successful users (Steiner, 1994).

In a study of heterosexual couples in which one partner was HIV positive, only one case of infection occurred among those who remained sexually active and used condoms consistently and correctly. In contrast, the incidence of HIV infection was 14% with inconsistent use (Deschamps, 1996). Another study found that among a group of couples who used condoms consistently, 2% of the uninfected partners contracted HIV over the course of the two-year study. This contrasts with 12% of partners who became infected in couples that reported inconsistent or no condom use (Saracco, 1993).

Other Concerns

Another important caveat to Smith’s study is that she only included men who reported sex with an HIV-positive partner. So a man who used a condom one time with an HIV-positive partner but never used a condom with 100 presumed HIV-negative partners would still have been included in the “always used” group. And in fact, the men who reported they always used a condom with HIV-positive partners said they were less likely to use a condom with partners they thought were negative. If those partners actually had HIV, that could account for some of the infections in the “always use” group, making the 70% number artificially low.

Finally, I looked at that 50% figure some gay men mention. That comes from a 2014 study by Robert Remis, which concluded:

Among Ontario MSM in 2009, an estimated 92,963 HIV-negative men had 1,184,343 episodes of anal sex with a condom and 117,133 anal sex acts without a condom with an HIV-positive partner. Of the 693 new HIV infections, 51% were through anal sex with a condom.……

Really? That was far lower than even Smith’s study. Why such a dramatic difference? Well, it turns out that Remis’ study is simply a mathematical model. No one was actually enrolled or followed over time – it was all based on estimates. First, the authors estimated the number of MSM in Ontario, using the last census – but how reliable is that? Then, they estimated that the “annual number of anal sex acts per person” was 100 – seriously? Then they estimated that 91% of them used a condom for anal sex – once again, seriously? They then looked at the number of MSM with HIV in Ontario, and estimated that 51% of HIV infections occurred during anal sex with a condom. They also said that estimate could range from 7% to 77%.

The many different things estimated in this analysis make it highly questionable, and also account for the broad range of the estimate. For those reasons, I won’t be using it in any of my workshops.

Using the Damn Things

Of course, the real question is: will people use condoms? When it comes to gay men, the answer seems to be “no”. Smith’s study found that “only 16% of MSM reported consistent condom use during anal sex with male partners of any HIV status over the entire observation period.” Other studies have also found low rates of consistent use – an internet survey conducted by George Mason University asked over 14,000 MSM if they had used a condom the last time they had anal sex. Over 56% reported that they knew their partner had had sex with other men in the prior six months. In spite of that, condom use ranged from 26% to 56% – clearly not high enough to make a dent in the epidemic.

Even so, we need to get the facts out to young gay men about condom effectiveness, and we must respond to statements like this from a recent Facebook debate:

With high local prevalence and less-than-pristine condom use, condoms are very nearly worthless…. [Y]ou guys lied about that and obfuscated it for decades. It’s STILL the easiest fact to troll condom- nazis with, drives them NUTS. That remains proof that activists’ omissions, lies and distortions about condoms lasted far longer and embedded more deeply than any lies or distortions about PrEP.

Do younger gay men really think there was some kind of conspiracy of silence coordinated by safer-sex advocates to overestimate the efficacy of condoms? What would motivate gay men to lie to other gay men about something as critical as condom effectiveness? That’s the kind of malevolence we used to ascribe only to people like Jesse Helms. Should we now accuse each other of it?

We must educate young gay men about proper condom use. Perhaps one part of the problem is that gay men no longer get in-person condom demonstrations that
were common in safer sex workshops in the ’80s and ’90s, and so never learn the steps so important to their correct use. AIDS activists fought long and hard to get condom demonstrations in high schools. But do they still happen? The teens I’ve talked to say HIV education in high schools is sorely lacking – particularly when it comes to gay sex.

Another thing that has always bothered me is that I’ve never seen a porn actor actually put on a condom. There’s lots of bad dialogue and foreplay and then – cut – the condom is magically on! Would it be that much of a turn-off to show the guy actually put it on? Think how many thousands of gay men could have learned proper condom technique in a fun and sexy way if that had been done for the last 30 years.

But if many gay men don’t use them, does it matter how well they work? Yes – it matters because we need more, not fewer, prevention options. Adding PrEP to the prevention arsenal is an important step that could dramatically change the course of the epidemic. But gay men need to know that even if they’re not on PrEP, it’s possible to protect themselves. Many men have done that for years. If you use a condom correctly every time you have anal sex, your chances of getting HIV are extremely low. And, unlike PrEP, condoms offer protection against other STDs, like hepatitis C, not to mention being far cheaper than Truvada, which can cost over $10,000 a year.

Conclusion

Here’s what I learned while researching this article:

- The CDC has not said that condoms are only 70% effective for anal sex.
- A CDC researcher reported that an analysis of two 1999 studies found 70% fewer infections when comparing men who said they used a condom every time for anal sex to men who said they never used them.
- Studies have found that people often tell researchers they used a condom more often than they actually did.
- Studies of condom failure rates have found that when used correctly, they break or slip about 2% of the time during anal sex.
- The majority of gay men do not use a condom every time they have anal sex.

The reality is that the message “Use A Condom Every Time” has not worked, and is not going to work well enough to stem the epidemic. Fortunately, we have a new tool, PrEP, that (once again, when used correctly) may match condoms in effectiveness. Studies of microbicides are ongoing, and hopefully will show positive results soon. And intermittent PrEP and long-lasting injectable PrEP will soon be important additional options.

We should also address the aversion many men have toward condoms. For many gay men, skin-on-skin contact is an important part of sexual intimacy. But others just don’t like the way a condom feels. For them, finding the right lube is essential, as is choosing the right condom. Polyurethane condoms, available since the ’90s, offer the advantage of allowing users to choose any lube they like – including oil-based products like hand lotion – removing one of the major reasons for condom failure.

So, are condoms over? No. The availability of new prevention options does not require us to abandon a tool that has been proven effective for decades. Let’s move forward in the search for new prevention options without bashing the ones we have – or those who promote them.

Mark Milano is the Editor of Achieve.
Over a decade ago, doctors in Europe began reporting clusters of new hepatitis C infections among HIV-positive gay and bisexual men. Given their lack of other risk factors, the culprit appeared to be sexual transmission.

This was greeted with surprise and skepticism, as it was assumed that sexual transmission of hepatitis C virus (HCV) was rare. But today there is a growing consensus that sex is a leading cause of new HCV infections among men who have sex with men (MSM), especially those who have HIV.

“Among gay men, I think the vast majority who acquired HCV in the past decade have gotten it from sex,” says Daniel Fierer from Mount Sinai Medical Center in New York City.

HCV is a blood-borne virus that had been most often transmitted by sharing needles or by blood transfusions (before blood was tested for the virus). The CDC lists sex as an “inefficient means” of HCV transmission. Public health messages have said that the risk of sexual transmission is very low and that people with HCV do not need to change their sexual practices. This advice was based on studies showing that transmission is rare in monogamous heterosexual couples, ranging from 0% to about 3%.

But these findings don’t hold for other groups. Other studies have shown that both heterosexual and gay people with multiple sex partners, HCV-positive partners, or partners who inject drugs have a higher chance of getting hepatitis C.

HCV and HIV

Because the transmission routes are similar, about a third of people with HIV also have HCV, and many people who got HIV through injection drug use also have HCV. But among gay and bisexual men with HIV, sex appears to be increasingly common as a means of HCV transmission.

“For gay men who don’t inject drugs but have a lot of sex, if they get HCV, they’re likely to have gotten it through sex,” says Brad Hare, Director of HIV Care and Prevention at Kaiser Permanente in San Francisco.

In 2002 researchers reported several cases of new HCV infections among HIV-positive gay men at sexual health clinics in London. Within a year, the number of new cases approached 50. Before long, similar clusters were reported in France, Germany, the Netherlands, and Switzerland. These were followed a couple of years later by reports from Australia, the U.S., and Japan.

New HCV infections in gay men with HIV began to climb steeply around 2005. Investigators from Amsterdam’s public health service have traced HCV prevalence, or total cases, among HIV-positive gay men over two decades. The proportion of these men testing positive for HCV antibodies rose from 6% in 1995 to a peak of 21% in 2008, with nearly one-third having a new infection. The number then appeared to level off, which the researchers said could be due to greater awareness and prevention, or just that the pool of susceptible men was “saturated”.

Similar reports emerged a bit later in the U.S. In 2006 Annie Luetkemeyer reported nine cases of new HCV among men with HIV seen at San Francisco General Hospital, with a majority reporting only sexual risk factors. The next year, Fierer first reported on a group of HIV-positive gay men in New York with new HCV infections despite no traditional, non-sexual, risk factors. Disturbingly, some of them had unusually rapid liver fibrosis. And in 2009, Lynn Taylor reported that 75% of new HCV infections among HIV-positive gay and bisexual men in several AIDS Clinical Trials Group studies were likely due to sexual transmission.

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Genetic studies have shown that HCV strains from MSM closely follow sexual networks within and even across cities. Several HIV-positive gay men in European cities, for example, were infected with HCV genotype 4, a Middle Eastern strain that is otherwise uncommon in Europe. Notably, the HCV strains circulating among gay men are usually not closely related to the strains circulating among people who inject drugs in the same city.

HIV-Negative Men

By now the risk of HCV sexual transmission among HIV-positive gay and bisexual men is widely recognized. But what about their HIV-negative counterparts?

Since the topic first hit the radar a decade ago, researchers have seen few cases of apparently sexually transmitted HCV in HIV-negative men. But some experts have suggested that sexual transmission of HCV among HIV-negative men is found less often only because we don’t look for it. HIV-negative people are seldom tested for HCV and don’t usually have regular liver function tests. But the few studies that have specifically looked for HCV in HIV-negative gay men have found infection rates similar to those of the general population.

After clinicians in Brighton, England, observed a high rate of new HCV infections among men with HIV at their sexual health clinic, they decided to test all clients, regardless of HIV status, starting in 2000. While several cases of HCV were detected among HIV-negative men, they were 13 times less likely to get it than HIV-positive men.

In Amsterdam, while HCV prevalence among men with HIV rose from 6% to 21% between 1995 and 2008, cases in HIV-negative men stayed low and stable at around 0.5%. Other studies in Sweden, Switzerland, and the U.K. have seen HCV prevalence rates among HIV-negative gay men ranging from 0.2% to 0.7% similar to the general population of those countries.

At last year’s ICAAC meeting, Katie McFaul from Chelsea and Westminster Hospital reported finding 44 HIV-negative gay men with new HCV at three sexual health clinics in London, out of about 34,000 clients tested for the virus (a rate of less than 1%). At the same conference, Swiss researchers reported that only one out of 654 mostly HIV-negative gay men tested at their clinic had HCV. His only risk was condomless anal sex.

What Are the Risk Factors?

A wide range of risk factors have been linked to HCV among MSM, including anal sex, fisting, rimming, multiple sex partners, group sex, sex at sex clubs or bathhouses, use of non-injected recreational drugs, sex while using drugs, and having other sexually transmitted diseases (STDs). Injection drug use does not appear to play much of a role.

The strongest predictor of HCV among gay men is anal sex, especially receptive sex without a condom. In some studies, every man with new HCV reported being an anal sex bottom.

This raises the question of whether HCV is sexually transmitted mainly through blood or through semen. HCV is known to spread most easily through direct contact with infected blood. Some experts, therefore, have concluded that HCV transmission is probably due to exposure to blood during sex.

Some sex activities like piercing and whipping can cause bleeding, and one recent study from Amsterdam found that gay men in the leather, rubber, or denim scenes have higher HCV rates. But sex doesn’t have to be “rough” to be risky. Anal intercourse can cause small tears in the rectal lining that could increase the likelihood of infection.

“Researchers talk about traumatic sex, but that’s an unfair thing to say about gay men,” says Fierer. “Do they mean all anal intercourse is traumatic? People don’t identify their anal sex as traumatic.”

Even hangnails or minor cuts on the hands, genitals, or elsewhere could provide a portal for viral entry or exit. The amount of blood doesn’t have to be large or even visible to allow for HCV transmission. “It doesn’t have to be some blood-letting exercise,” Fierer stresses. Being fisted, using sex toys, or bottoming with multiple partners can injure the rectal lining, providing easier access for the virus. During group sex, HCV in blood or semen may be transferred from one person to the next on penis, fists, or toys.

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Non-injection drug use may play a role if people share straws or rolled bills for snorting drugs or pipes for smoking, since small amounts of blood may be left on the equipment. Some drugs enable prolonged sex, while others can dry out mucous membranes or cause numbness that allows more vigorous penetration.

Other STDs, including syphilis and genital herpes, cause sores or ulcers that make it easier for HCV to get in and out of the body. Anal warts caused by HPV may also add to the risk. Other infections like gonorrhea and chlamydia cause inflammation that may aid HCV transmission.

It’s difficult to tease out the specific contributions of various risk factors because multiple activities often occur together and most gay men do not have only one kind of sex. If an HIV-positive man with undiagnosed chlamydia takes ecstasy and goes to a sex club where he fists one partner, is penetrated with a previously used sex toy, and then bottoms for anal sex, it’s hard to tell which of these factors is to blame if he gets HCV.
HCV infection.

“Hepatitis C is more efficiently transmitted through blood and less through sex, so if a gay man has both types of exposure, it’s probably blood that’s causing it,” Hare summarizes. “In the absence of blood, semen is a less efficient but possible route of transmission.”

Several studies have detected HCV in semen, though usually at low levels and not all the time. One Australian study, for example, found that 44% of men with HCV had detectable virus in their semen at the start and 74% did at least once during follow-up. Other research has shown that men with HIV have higher HCV viral loads and are more likely to have HCV in their semen than HIV-negative men. Furthermore, men with new HCV infection have more HCV in their semen than those with chronic infection.

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Unanswered Questions

Why does sexually transmitted HCV mainly occur among men with HIV and why did it seem to crop up around the year 2000, even though gay men were having plenty of sex, doing drugs, and getting STDs long before that?

Overall immune deficiency may play a role in making HIV-positive men more susceptible to HCV, but many men with sexually transmitted HCV are on HIV treatment with undetectable HIV viral loads and high CD4 counts. Some started HIV treatment early and never experienced serious immune system damage. Current or lowest-ever CD4 cell count are not predictors of HCV infection. This suggests that the problem is not simply that a weakened immune system cannot fight HCV. Even well-controlled HIV leads to inflammation and subtle immune damage starting soon after infection, and that may facilitate HCV transmission.

“HIV significantly affects the immune system that lines the gut,” Hare explains. “I think the best explanation is that once the immune system is damaged, it does not fully recover even if the blood CD4 count is normal, so [people with HIV] may be more vulnerable to HCV in the rectum.”

People with HIV are not only more at risk for getting HCV, but are also more likely to transmit it. Studies have found that men with HIV have higher HCV viral loads and more often have detectable HCV in their semen than HIV-negative men.

According to Lars van de Laar and colleagues studying the HCV outbreak in Amsterdam, viral evolution patterns imply that the virus was occasionally introduced into networks of gay men between 1975 and 1996, but that it didn’t really take off until the late 1990s. Then, with the development of effective HIV treatment, men with HIV returned to active sex lives as their health improved. Serosorting (HIV-positive men having condomless sex with each other) led to more sexual transmission of HCV, along with other STDs.

Because sex is an inefficient way to transmit HCV, Fierer thinks it took a while for it to reach critical mass. Outbreaks were seen first in European countries because their centralized health systems collect data from a large number of people, allowing patterns to emerge sooner than in the U.S. HCV outbreaks occurred first among HIV-positive gay men, and serosorting tended to keep HCV within that population.

“In the ’70s in the Castro or the West Village, HCV prevalence wasn’t high, so men couldn’t transmit it to each other,” he suggests. “Over the years the seroprevalence rose until it reached the level of transmissibility, which happened remarkably around the same time in multiple cities around the world after decades of not seeing it.”

The Role of PrEP

Just as condomless sex among serosorters may have triggered outbreaks of HCV among gay men with HIV, some fear PrEP could have a similar effect among HIV-negative men.

PrEP (pre-exposure prophylaxis) refers to HIV-negative men taking daily Truvada to prevent HIV infection. Although most studies have shown otherwise, it is widely assumed that many men taking PrEP either already do not use condoms regularly or would like to use them less, leaving them vulnerable to other STDs, including HCV.

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At Kaiser Permanente in San Francisco — the largest PrEP provider in the U.S. — more than 500 people, mostly MSM, started PrEP from early 2012 through July 2014. While there have been no new HIV infections, other STDs have been common, including two cases of HCV — an incidence rate of 0.7% per year. Both were gay men with multiple sex partners who had other STDs but reported no injection drug use or occupational exposure, leading Hare to conclude, “I’m comfortable saying both are sexual transmissions.”

At this year’s Conference on Retroviruses and Opportunistic Infections, Sheena McCormack reported four new HCV infections among 545 HIV-negative men in the U.K. PROUD study of Truvada PrEP. Jean-Michel Molina reported eight new HCV infections among 400 men in the French Ipergay study, which tested on-demand PrEP. Both studies saw no new HIV infections, but other STDs were common.

In McFaul’s study of 44 HIV-negative men with new HCV infections in London, two were participants in a PrEP trial and eight had received HIV post-exposure prophylaxis (PEP) within the previous six months. “I worry Truvada could completely change the equilibrium,” says Fierer. “Now men are not getting HIV, but they can still get HCV. As men become more confident about PrEP, unprotected sex becomes more and more common. It can have unintended consequences, like serosorting did. There’s always something out there willing to take advantage.”

CDC guidelines recommend that people should be tested for HIV and other STDs before starting PrEP and every few months while taking it. Kaiser’s PrEP program includes annual HCV testing and liver function monitoring every three months. Both of the new HCV infections to date were detected because the men had high levels of ALT, an enzyme that rises during liver inflammation.

While PrEP could contribute to a rise in HCV by reducing condom use, it could also potentially have the opposite effect because it prevents HIV, which is the biggest risk factor for HCV among gay men. And the accompanying regular testing detects HCV early, which could interrupt transmission.

“It’s important for HIV-negative men thinking about PrEP to be counseled about HCV,” Hare stresses. “If they’re maybe going to decrease their condom use, they should know HCV is a risk. We talk about other STDs, but HCV is the big one to be concerned about.”

Conclusions
The uncertainty around sexual transmission of HCV makes it hard to offer definitive advice. We need to raise awareness about sexual transmission of HCV and to fight stigma so people can talk about it openly.

“There is so much uncertainty around the sexual transmission of HCV, especially when compared to other STDs like HIV or syphilis,” says Andrew Reynolds, Project Inform’s Hepatitis C Education Manager. “So we struggle with our educational messages or err on the side of caution. Nobody wants to tell a person they are not at risk, only to find out later that we were wrong.”

HCV Prevention
Compared with HIV, HCV is a tougher virus and can live longer outside the body. Research shows that HCV can live in syringes for more than a month, in water (and maybe in lube) for a couple of weeks, and on surfaces for several days.

Most experts recommend using condoms for anal sex, which would offer good protection if HCV is spread by semen, and some protection if it is spread by blood. For men who have sex with women or transgender men, menstrual blood is a potential concern.

“The same sort of strategies that work for HIV could work for HCV,” Hare says. “Condoms could be helpful, though we can’t say for sure — if transmission is through semen, it’s helpful.”

Gloves can potentially protect both tops and bottoms during fisting. Putting condoms on dildos or other sex toys helps keep things clean. During group sex, change condoms or gloves between partners, since HCV may be transferred from bottom to bottom on penises, fists, or toys. It makes sense to clean sex toys and surfaces after sex and between users.

Hare recommends using new condoms and clean gloves for each partner, and cleaning sex toys between uses. But, he acknowledges, “How best to clean is not clear — even bleach may not be 100% effective [against HCV]. So I advise having multiple sets of toys that can be used for different partners — lots of equipment is good!”

Unfortunately, there is no vaccine for HCV. And people who clear the virus either naturally or with treatment can get infected again. Some European studies have seen reinfection rates around 15%, with some men being reinfected two or even three times.

HCV Screening
Guidelines recommend that all people should be tested for HCV at the time of HIV diagnosis, regardless of risk. In addition, the CDC recommends a one-time screening for all “baby boomers” (people born between 1945 and 1965). This age group accounts for about 80% of all HCV cases in the U.S. But a majority of
men with sexually transmitted HCV are considerably younger, in their 30s and 40s. According to the CDC, “Testing for hepatitis C is not recommended for gay and bisexual men unless they were born from 1945 through 1965, have HIV, or are engaging in risky behaviors.”

AASLD/IDSA guidelines released last year recommend annual HCV testing for people who inject drugs and for men with HIV who have unprotected sex with men, adding, “Periodic testing should be offered to other persons with ongoing risk factors for exposure to HCV.” But those risk factors remain undefined.

Many providers do not recommend – or may even discourage – testing for men with only sexual risk factors. But this is starting to change, especially in cities with large gay communities. A growing number of experts think annual HCV testing is good practice for men with ongoing sexual risk, including HIV-negative men.

Regular liver function blood tests (ALT/AST) can also be useful for detecting a new HCV infection. ALT typically rises soon after HCV infection, before antibodies are produced (which can take up to six months).

“HIV-positive people should probably have their ALT checked every six months, maybe every three if they have a lot of risk,” adds Hare. “If HIV-negative, they can have less frequent monitoring.”

**Treatment as Prevention**

HCV treatment has changed dramatically over the past few years. Oral antivirals that target steps of the HCV lifecycle have replaced interferon and ribavirin, which had to be injected weekly for 6 to 18 months, caused difficult side effects, and cured only about half of people.

The FDA has now approved three oral HCV medications which can cure over 90% of people. Treatment lasts 12 weeks for most people and is very well tolerated. Many experts now think everyone with HCV should be eligible for prompt treatment, before developing advanced disease. This may be especially important for people with HIV, who can have rapid liver disease progression.

Today the main barriers to widespread treatment are people not knowing they have HCV and the high cost of the new drugs. With a list price of $80,000 to $95,000, many insurers are limiting access to the sickest patients, and government payers like Medicaid and prison health services do not have enough money to treat everyone.

So even though HCV is now easier to treat, it shouldn’t be taken lightly. It isn’t like syphilis, which can be quickly cured with a dose of penicillin, and it shouldn’t be regarded as an expected part of an active sex life.

“Getting hepatitis C is certainly more serious than other STDs,” says Hare. “Treatment is not a single shot – it’s more expensive and more intensive.” While people who get HCV should receive prompt care, there’s no demonstrated benefit to offering HCV drugs immediately after exposure, as is done for HIV. “There’s no HCV PEP or PrEP,” he adds.

It took ten years after the development of effective HIV treatment before we realized the benefits of HIV treatment as prevention, but this is already being discussed for HCV. With widespread treatment, some experts envision its elimination. Modeling studies by Gregory Dore at the University of New South Wales and his colleagues have shown that expanded treatment could dramatically reduce HCV transmission among people who inject drugs, and the same could be true for sexual transmission among MSM.

“To stop transmission, we need to treat the people who are actively transmitting,” stresses Fierer. He estimates that while there are about three million people with HCV in the U.S., active transmitters are only in the thousands. “We need to get these guys treated as soon as we can. We should reconsider the idea of waiting for spontaneous clearance (see box on page 9). Instead of saving money, you may have caused extra infections. At this point, maybe we should just treat everyone as soon as we find them – get them in and get rid of it.”

Liz Highleyman is editor-in-chief of HIVandHepatitis.com and has written about HIV and hepatitis for various publications for 20 years.
I used condoms for most of my early sexual experiences, but I remember having mixed feelings about them. They would supposedly protect me from HIV and STDs, but they felt awkward and uncomfortable. I also had concerns about how effective they truly were. I would use condoms most of the time, but still worry both during and after sex that I might be exposed to something. I think my lack of confidence in condoms came down to not having the self-belief to use them every time and to my concern over how much protection they provided. In the end, I set aside pleasure and focused on the abstract concept of protection. To me, it comes as no surprise that a guy might forgo condoms in favor of serosorting (only having sex with someone he believes to be HIV negative).

The two times I clearly remember having unprotected sex were with men at least twenty years older than me. Another two times I had sex and worried about it afterward were with men at least five years older than me. I recently came across one study saying that sexual relationships with older men contribute to the rise in HIV infection rates among young Black MSM. I began to wonder whether this was also true for young Latino MSM and how power plays a role in condom negotiation between young men and their older partners.

One guy kept reassuring me he was HIV negative. Even though I insisted numerous times that we use a condom, he wound up getting his way. For three months after that encounter, I was constantly worried that I could’ve been exposed to HIV. I didn’t seem to have issues using condoms with most other partners, so why didn’t I demand one in this situation? Another guy also reassured me he was negative, but this time I was the insertive partner. The next day, I decided to play it safe by going to the emergency room for post-exposure prophylaxis (PEP). Four hours later, I left the emergency room without PEP, since I was considered to be at low risk, and a $500 bill I didn’t know how to foot. At age 21, I was most concerned with...
keeping this episode a secret from my parents, especially my Mom, so I did everything I could to make sure she wouldn’t find out. With both of these guys, I was at their place. I wonder if that had an effect on my decision-making.

There were also a couple times I chose to have casual sex with guys with HIV. Even after they told me their viral load was undetectable, I initially rejected them. They both told me what undetectable meant, but I remained hesitant. I didn’t want to be a person who discriminates against someone with HIV, so to prove to them – and to myself – that I wasn’t, we hooked up. Granted, one occasion was just unprotected oral sex and the other was protected anal sex. Regardless, the issue back when I was first starting out was the lack of education needed to make an informed decision, not one based on guilt.

I went to the student health center to inquire about HIV testing. The nurse began preaching to me that this wouldn’t have happened had I “been following God’s will.”

I wouldn’t want anyone else to go through the fear and uncertainty that comes with making an uninformed decision. Following the unprotected oral sex, I went to the student health center at Texas A&M University to inquire about HIV testing. After I told the nurse my reason for being there, she began preaching to me that this wouldn’t have happened had I “been following God’s will.” Her harsh words led to feelings of shame and regret, and I was brought to tears. I wish I could have had the confidence and knowledge back then at the age of 20 to correct and then report her.

I feel like I have come a long way in educating myself about HIV, but I know I still have a long way to go. My friends and I now have an awesome relationship where we can talk openly about our sexcapades. Since turning 21, we offer each other quasi-counseling, which is the best we can do for the moment. Usually we’ll talk about the circumstances that led up to meeting the person, whether protection was used, and our sexual health in general. Being able to talk about these things lets us know that we care about each other and gives us a way to think about our sexual health. It’s important to be able to do this because sex is everywhere, yet we talk about it (or don’t) as if it’s something we don’t do.

Six months ago I started pre-exposure prophylaxis (PrEP) and I’ve encouraged my friends to research it and decide if it’s right for them. At the age of 23, I have a new outlook on sex. I’m able to worry less and sleep better knowing I have an extra tool to protect myself. In fact, I’ve reduced my number of partners and am now more concerned about protecting myself from other STDs, like HCV.

As a society, we need to demand more for those coming after us. This includes comprehensive sex education in all schools that covers HIV, other STDs, and pregnancy prevention, along with abstinence. In addition to benefiting young people throughout their lives, I think it has the potential to alter the HIV epidemic and the current health disparities we face.
We must move beyond targeting only the risk behaviors of vulnerable groups to address the root causes of the inequalities that prevent self-empowerment, create chronic stress, impair the immune system, and block access to treatment. We must not undermine behavioral interventions that have been successful. But we should accept that such interventions alone will never be able to change the harsh racial disparities of the epidemic.

Access To Care
We now have powerful drugs that can treat HIV, prevent its transmission, and prolong life, but they’re reaching only a fraction of the people who need them. The goal of HIV treatment is for everyone to achieve viral suppression – but only half of MSM with HIV in the U.S. are on treatment. And only 40% of Latino MSM achieve viral suppression. We also know that Latinos are being connected to care at a much later stage of HIV disease and are more likely to be diagnosed with AIDS at the same time they learn they have HIV.

Among the many barriers to early diagnosis and treatment are poverty and lack of insurance, even though HIV drugs are covered by Medicaid and the Ryan White program fills the funding gaps that aren't covered by Medicaid or private health insurance. In many states, the Affordable Care Act has helped many people obtain coverage through insurance marketplaces. But even so, many Latino MSM are not eligible for health insurance, especially if they are undocumented. Latinos continue to be the most uninsured racial/ethnic community in the U.S.

Looking at over 170 media stories, Richard Pitt concluded that “down low” bisexual men of color were often described negatively as deceitful men who threaten the community. White bisexual men were often portrayed as victims, forced into the closet by society.

The mass media offer damaging explanations for the differences in HIV infection among racial groups. Looking at over 170 media stories between 2001 and 2006, sociologist Richard Pitt concluded that “down low” bisexual men of color were often described negatively as deceitful men who threaten the community. White bisexual men were often portrayed as victims, forced into the closet by society.

Health Disparities
Social determinants – the conditions in which people live – strongly affect their risk of HIV and the course of their disease. Behavior, while important, does not fully explain the difference in risk among racial and ethnic groups. Instead, the racial HIV gap and the racial health gap in general are strongly linked to the racial wealth gap, which in turn is the direct outcome of segregation and inequalities in housing, education, employment, and health care, as well as racially skewed incarceration.

The higher rates of HIV in communities of color are not simply the result of high-risk behavior, but of the inequalities that make their members more likely to come in contact with the virus and less likely to treat it.

Latino MSM (men who have sex with men) face multiple barriers to HIV prevention, care, and treatment. This is due in large part to programs that fail to address the homophobia, transphobia, racism, stigma, and anti-immigrant sentiments they face. In the past twenty years, rates of HIV infection among Latino MSM have consistently increased.

Latinos have HIV infection rates three times those of whites, and MSM account for over 80% of cases among Latino men. In addition, certain groups are at even higher risk, such as younger Latino MSM and those born outside the U.S. For the undocumented, their immigration status creates an additional stressor that makes HIV testing and being retained in care more challenging.

Identifying Needs, Eliminating Barriers

by Luis Scaccabarrozzi

Latinos have HIV infection rates three times those of whites, and MSM account for over 80% of cases among Latino men. In addition, certain groups are at even higher risk, such as younger Latino MSM and those born outside the U.S. For the undocumented, their immigration status creates an additional stressor that makes HIV testing and being retained in care more challenging.

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Minority Stress
The term “minority stress” is used to express the personal impact of prejudice and stigma from society. It refers to the cumulative effects of residential segregation, educational and economic inequalities, disparate treatment by the criminal justice and mental health systems, and other negative factors not experienced by the majority (white Anglo) community. Minority stress is linked with anxiety, depression, loneliness, and low condom use among Latino MSM.

Segregation
Residential segregation by race and ethnicity remains a reality for many Americans. The average white person lives in a community that is 80% white, the average African American lives in a community that is over 50% black, and the average Latino lives in a community that is 46% Latino. People who live in low-income minority neighborhoods are significantly less likely to receive early HIV testing and treatment. These differences stem from the deteriorated physical conditions and environmental stressors of these neighborhoods and from their relative remoteness from quality medical testing and health care sites. HIV infection rates are so high in some neighborhoods of color that they are on par with levels seen in Ethiopia and Haiti and meet the United Nations’ definition of a “generalized HIV epidemic”.

This segregation shrinks a community’s social networks, which ultimately increases the “community viral load”. A person’s viral load is an important measurement of the amount of HIV in the blood and affects whether he or she will transmit HIV, and that contributes to and interacts with his or her community’s viral load. Thus, someone who has unprotected sex with a partner from a neighborhood with a high community viral load has a much greater HIV risk than someone who has sex with a partner from a neighborhood with a lower community viral load.

Income Disparities
Almost 25% of U.S. Latinos live below the poverty line, employed only part-time or intermittently and pushed into economic insecurity. Latino men are often excluded from all except the lowest paying jobs refused by others. A study of Latino MSM in New York City found that 53% earned less than $15,000 a year, with most below the poverty line. Among gay Latino men, a connection has been shown between financial hardship and the psychological distress that can lead to risky sexual behavior.

Immigration Issues
A person’s country of origin is one important factor when looking at risk factors in different groups. Researchers must pay attention to diversity among Latinos in terms of countries of origin as well as mobility, because it affects their risk behaviors. For instance, Dominicans may negotiate HIV risk and protective behaviors in relationship to the centrality of family reunification as a strategy of immigration among much of this population. By contrast, such negotiations may look quite different for Mexicans and Central Americans living on the East Coast, where there tend to be large imbalances between the numbers of immigrant men and the largely absent or very small numbers of women. In both cases, men may have sexual activity with partners outside of a primary relationship.

The conditions leading to risky behaviors among men and women must be understood as distinct from each other – an important nuance that is often glossed over by relying on terms such as “Hispanic” or “Latino” when describing these diverse populations.

Undocumented people fear “the system,” including the risk that seeking medical help could lead to deportation or other legal problems. Non-English speakers (often parents) must rely on English-speaking relatives (often their children) to communicate with health care providers. In order to obtain testing or treatment, such immigrants may have to sacrifice privacy.

Cultural Homophobia
The diversity of Latinos in the U.S. makes generalization difficult, but homophobia is especially high across Latino cultures. Certain beliefs about masculinity can increase shame and make MSM more likely to hide their sexuality. Montgomery and Mokotoff followed 5,156 MSM with HIV from 1995 to 2000 and found that 34% of Black MSM, 26% of Latino MSM, and 13% of white MSM reported also having sex with women. The authors concluded that bisexual activity is relatively common among
Black and Latino MSM with HIV, that few identify as heterosexual, and their female partners may not know of their bisexual activity.

Lesbian, gay, bisexual, and transgender immigrants face multiple challenges that are often made invisible by the predominant view of immigrants as heterosexual. Research suggests that sexual minorities are able to immigrate by relying on friends, not family. This may help immigrants deal with disclosure and discrimination by creating distance from their biological families. But it also means that the support they may need from their family abroad will require discretion. Access to HIV prevention or care resources may require involvement with gay-identified groups, which may not appeal to certain immigrants. In addition, family reunification statutes in immigration law may not apply to same-sex partners.

Migration does not protect immigrants from the social norms they sought to escape. People fleeing from HIV stigma continue to confront it, including within sexual minority communities (based on their immigration status, race, ethnicity, or HIV status). The mental health effects of stigma might increase the vulnerability of sexual minority immigrants to behaviors that put them at increased risk for HIV, such as injection drug use, alcohol, and unprotected anal sex. Women and gender-nonconforming people may be vulnerable to rape and violence.

Family

“Familism” is important in many Latino cultures. A high value is placed on the immediate and extended family for support, emotional connection, loyalty, and solidarity. Familism often plays a positive role in the lives of Latinos in the U.S. For example, strong bonds of family support have been linked to high self-esteem, low rates of substance abuse, and the ability to negotiate condom use among Latino adolescents.

But familism can be a source of conflict for Latino MSM. It is often the frame through which they understand and organize their sexuality. This often means they internalize a sense of shame, which leads them to keep their same-sex behavior secret in order to preserve family honor.

Fortunately, research has also shown a generational divide between Latinos who are older, more religious, and inclined to traditional views about gender and sexuality, and younger Latinos. This generational difference is possibly due to the rapidly shifting sociopolitical climate that is becoming more inclusive of LGBT populations.

Education and Awareness

Culturally sensitive sex education, and condoms, must be freely and easily available to all populations, especially to people at high risk for HIV. As the National HIV/AIDS Strategy notes, “it is important to provide access to a baseline of health education information that is grounded in the benefits of abstinence and delaying or limiting sexual activity, while ensuring that youth who make the decision to be sexually active have the information they need to take steps to protect themselves.”

There is a need for greater cultural competency among HIV service providers, public health officials, and advocates. Cultural sensitivity training should include information about local immigrant communities, their characteristics, and their challenges, in order to help immigrants navigate their unique barriers to HIV testing, disclosure, and treatment. Since immigrant communities are subject to immigration laws and regulations, which vary by state, public health officials must be educated on the impact of those laws on the ability of immigrants with HIV to access care.

Ensuring that immigrants in same-sex relationships can obtain family-based immigration benefits would also help reduce their vulnerability. President Obama’s recent Executive Order on immigration is seen as a step forward, but it might not have any effect on LGBT communities. And Congressional efforts to block it make its future uncertain.

Conclusion

One of the biggest barriers to health equity is HIV stigma and silence. In communities of color, the stereotype of HIV as the consequence of “deviant” behavior has persisted and discouraged people from testing and treatment. By expanding the HIV discussion to include the societal factors that contribute to high HIV rates among Blacks and Latinos, we can shift the stigma away from individuals and extend responsibility to the systems and communities themselves. Further, the conditions that increase HIV risk are often the same ones that create health inequities in communities of color. An integrated focus on health and wellness will go a long way toward reducing stigma and, in turn, the epidemic in communities of color.

Recommendations

- **Research on Access:** Examine and eliminate societal barriers that prevent Latino MSM from seeking HIV prevention and care services. There is little information on adapting interventions in culturally sensitive ways.
- **Mental Health Research:** Research has identified such mental health issues as loneliness, depression, family stress, discrimination, and stigma. They can significantly affect healthy functioning, well-being, and ability to use services.
- **Prohibiting Discrimination Based on Sexual Orientation or Gender Identity:** Ensure that same-sex marriages are treated equally to opposite-sex marriages. Agencies that receive state funding must revise procedures to ensure that same-sex spouses receive equal treatment regarding patient rights and services such as family visitation.
- **Improving Data on LGBT People:** To better understand and address the health care needs and health disparities of Latino LGBT populations, ensure that questions on sexual orientation and gender identity are included in all surveys.
- **Collaborations:** Build strong, effective partnerships with the federal government, state and regional health departments, and community-based organizations, health care providers, LGBT service organizations, key opinion leaders, and institutions across the U.S.
- **Latino LGBT Outreach and Enrollment in the ACA:** Assist LGBT individuals and families to find health care coverage that fits their needs and budget.

Luis Scaccabarrozzi is Director of Health Policy & Advocacy at the Latino Commission on AIDS.
He became my counselor. I considered taking my life, but his words made me dismiss those dark thoughts. He told me about the Broadway youth center in Chicago. It was hard for me to take that step but I finally went and made new friends. I would rotate my Friday nights between my friends and the ByC meetings. But I soon became depressed and tired of living a double life.

A few weeks before Christmas I began to feel that by drowning my emotions I was only drowning myself. I felt like I was trapped in a water tank, gasping for air, feeling desperation grab hold of me and pull me into the depths. So, on Christmas Eve, I told my closest friends. I was relieved at how well they took it. I was no longer submerged in my problem! I had reached land, and overcome my fears to move forward as an openly gay teenager.

Like any 18-year-old, the first thing I did was to look at porn videos. They were my introduction to gay sex, and to safe sex. Not the ideal source of information. I could always see a condom on the actors, but I never saw when it was placed there. It just magically appeared.

The first thing I did was to look at porn videos. I could always see a condom on the actors, but I never saw when it was placed there. It just magically appeared.

Since I was only 14, I knew I was a minor and shouldn’t call. But I did. I recorded my greeting, but said I was 21. Luckily, I caught the attention of someone who would become a key role model. He was the first person who taught me to love myself. After hours on the phone, I told him my real age. He was petrified, and said he had never intended to speak with someone of that age. But instead of taking advantage of my youth, he coached me and asked that we keep in touch. He never told me his full name or phone number. Instead, I would wait for his calls, glued to the phone on Tuesday evenings.

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I Googled gay night life and found Chicago’s “Boys Town”. I wasn’t old enough to enter the clubs, but I cruised the street until I found what I was looking for: a handsome stranger. We talked and decided to head to his car. He drove to a dark alley surrounded by warehouses, and I lost...
my virginity in the back seat of a car. It was painful, and I used no protection.

I had found what I was looking for, but it brought me no satisfaction. I was dropped off at the subway. The ride was emotional— an awkward sense of completion, followed by regret, disdain, and fear. I never realized how much danger I placed myself in that evening. I didn’t think how life-changing it could have been if the stranger had HIV. I’ve never actually put that into perspective until now, as I write about it. I was so naïve.

Some Mexican men feel they’re too much of a man to worry about a condom. They want to show their superiority. “You’re the one who wants it, so you should be okay with me doing it without a condom.”

I had never had an STD or HIV test, since I had not been sexually active. After opening up to the BYC staff, I tested negative and they asked me to join them at the 2006 Ryan White National Youth HIV and AIDS conference. That experience gave me the courage to finally come out to my mother and brother. I packed a suitcase and made arrangements to stay at a friend’s house, since I was ready to be disowned. To my surprise, both of them were supportive and helped me come out to the rest of my family.

Since then, I’ve had sex with and without protection. The decision to have unprotected sex was made amidst passion or while intoxicated. Like me, my friends are concerned about getting HIV, but they’re not all using protection. In the heat of the moment they might not, or they might think pulling out is enough. And it’s shocking that we just learned about PrEP a few months ago. Some of them have been to safer sex workshops, but I’ve learned everything online or from friends. For example, many Latinos are uncircumcised, but we never heard that being uncircumcised puts you at higher risk for HIV.

Now that I was out, being undocumented was like being in the closet all over again. I hid who I was and where I came from, even from my gay friends. My undocumented friends are very nonchalant about their sexual encounters. Because they have so many things to worry about, they have an “I don’t care” attitude about sex. They see HIV as the least of their worries. They have a lot of shame about it, so they know little about it. Just like being gay – people in Mexico are not very open about sexuality. So being gay and asking about HIV gives you two strikes.

I’ve found that some Mexican men feel they’re too much of a man to worry about a condom. That’s part of machismo. Especially the ones who have wives. They never want to wear a condom because they want to show their superiority. “You’re the one who wants it, so you should be okay with me doing it without a condom.” They feel that being a man gives them superiority over others. They make the money, so they make the decisions. The wife is just there to cook and clean and have sex the way they want it.

Being undocumented has also been a barrier to health care for me. It’s not easy for your employer to offer health care to someone who’s undocumented. If you apply for health care, the report might come back saying, “that’s not a good Social Security number,” and your employer would find out and have to fire you. That was a huge barrier – it wasn’t until I was able to get a work permit under DACA (Deferred Action for Childhood Arrivals) that my employer could offer me health insurance.

Five years ago, I started my first long-term relationship. We used condoms for about a month, but then we both asked, “Have you been tested?” and stopped using them. Most of my friends do the same thing if that trust is there. Not once did the idea of him having an affair surface in my mind. Not once did I believe he endangered my health by having sex with others. Unfortunately, we are no longer together since I found explicit text messages from other men on his phone. It became too difficult for me to trust him, and it also opened the door to my own infidelities. We still keep in touch, but I can’t see us getting together again.

One aspect to my life has never changed: my identity remains split. I am an immigrant who grew up in a beautiful city, thankful for all the opportunities, yet unable to call myself Mexican American. I am from neither here nor there. I can never relate to Mexican pop culture, politics, or trends like I do to those of the U.S. The fact is that I am no different than the children who used to ostracize me in sixth grade. I have more in common with them than anyone else. Hope is what pulled me through, and hope is what keeps me moving, through the work of President Obama and a DACA application.
In 2006, Greg Millett and colleagues studied HIV in African American men who have sex with men (MSM) to try to understand why they have the highest rates of infection in the U.S. His study reported that, compared with white MSM, African American MSM had fewer sexual partners, and found no differences in the rates of reported unprotected sex. They found no evidence to support theories ranging from genetic risk factors to increased substance use to higher incarceration rates. The men had similar histories regarding their use of sex workers, and similar HIV testing frequency.

In 2014, Maulsby and Millett published a follow-up review article which included data from new studies done after the initial 2006 study. The report found that African American MSM had higher rates of sexually transmitted diseases (STDs) and higher rates of undiagnosed HIV than their white counterparts. There was also evidence that they were less likely to be connected to care after testing HIV positive, and that they were less adherent to HIV treatment. But the question remained: why?

Here are the primary areas studied as likely contributing to the high rates of HIV infection in this community.

Social Networks
Researchers have concluded that the high prevalence of HIV in Black communities, coupled with high rates of undiagnosed HIV and STDs, might contribute to increased HIV transmission. This is supported by data showing that Black MSM are more likely to have Black partners, resulting in increased HIV risk (Tieu, 2010).

But some studies have found that choosing sexual partners based on race does not increase HIV risk in young Black MSM. This conflict might be explained by the findings of other studies showing that younger Black MSM engaging in unprotected sex with older MSM are at higher risk for HIV (Oster, 2011). The greater risk associated with these age choices has often been reported. But a lack of consistent definitions of “older” and “younger” makes the results inconclusive, and more research is needed.

Stigma and Discrimination
Acceptance of same-sex behavior, by social consensus or by law (marriage, anti-discrimination ordinances, etc.), is correlated with decreases in STD and HIV rates (Francis, 2010). As acceptance increases, more men become part of sexual social networks. This decreases the chance of partnering being limited to small networks, where the risk of HIV is higher. Put simply, the community viral load of a sexual network is decreased as it grows larger, and societal acceptance of homosexuality enables a sexual network’s size to increase. But homophobia remains high in many African American communities, which prevents social networks from increasing in size and thereby reducing their community viral load. Such homophobia also prevents MSM from establishing the long-term relationships that can reduce HIV risk.

African American MSM confront a powerful array of discrimination, including race, gender identity, sexual orientation, and HIV status. An assessment of U.S. attitudes toward homosexuality found that African American MSM were twice as likely to state that homosexuality was wrong as were white MSM. But researchers have not found a direct relationship between risk behavior and discrimination (Rhodes, 2011).
Health Care

Studies show that Black and white MSM are equally likely to have visited a health care provider in the past year. The CDC reports that MSM were offered HIV tests at the same rate: 61% of Blacks, 60% of Latinos, and 62% of whites.

But Black MSM had lower CD4 counts. Other studies report that African Americans are less likely than whites to adhere to HIV treatment or to stay in care. This is confirmed by CDC data showing that disease progression, infectiousness, and mortality are greater in Black MSM with HIV compared with other MSM. These differences in health outcomes are exacerbated by the fact that Black MSM have a greater chance of living in poverty, are less likely to have health insurance, and make fewer clinic visits when they do have health care. These differences may lessen due to the Affordable Care Act. But many states in the South, where HIV infection rates are high, have not expanded Medicaid as the ACA allows and so many continue to show these inequalities.

Mental Health

Research has consistently found that mental health issues, including depression, affect black MSM more frequently than white MSM. Many studies have focused on determining why these elevated rates occur. A common factor identified in the studies is widespread homophobia. However, research from the 1990s and more recently (deSantis, 2011) found no significant relationship between increased sexual risk behavior among black MSM and rates of mental health disorders. It appears that mental health alone does not explain the HIV infection rate disparities.

Mistrust

Mistrust of medical institutions by African Americans is well established. Many subscribe to HIV conspiracy theories and believe that HIV treatment is more toxic than the virus. But how that mistrust explains differences in HIV care and outcomes is not clear (Clark, 2008). This distrust underlines the need for every person to have access to safe and nonjudgmental HIV services. Unfortunately, research on how Black MSM interact with their medical providers is limited, and more is needed.

Condom Use

Flying in the face of high infection rates, studies such as the 2010 Indiana University National Sex Study reported that African Americans were more likely than other groups to use condoms. In fact, rates of condom use among Black teenagers were the highest of any group. But condom use declines in all groups after age 18, dropping as low as 20.5%, regardless of race.

People who interact with a sexual network that has more people with HIV are at greater risk for infection if condoms are not used. Black MSM with HIV are less likely to disclose their status, and are less likely to be on HIV treatment with an undetectable viral load (which greatly reduces the risk of transmission). Add to this the CDC report that the highest number of undiagnosed HIV infections are in African American communities, and we have some clues to inform prevention efforts.

Substance Use

Millet found that reported drug use during sex did not differ in Black MSM compared with white and Latino MSM. But researchers reported conflicting data, so more research is needed. Current data on substance use do not account for the higher rates of HIV in African American MSM. There are differences in the drugs of choice, with HIV-positive black MSM being more likely to use crack or cocaine and less likely to report meth (Maulsby, 2014).

Conclusion

A CDC presentation at the 2015 CROI meeting reported that 90% of all new HIV infections can be traced to people who are unaware of their HIV status, not connected to care, or not virally suppressed. Most of the studies in this article focus on health disparities. If these disparities were eliminated we would very likely see a drastic reduction in new HIV infections among Black MSM. But other MSM continue to see new HIV infections, even if not at the same rate. Eliminating disparities will not eliminate HIV infections. White MSM are not a model of optimal HIV prevention behavior – they are just a comparison group.

The HIV-related disparities Black MSM face may be due to barriers to care, low income, unemployment, incarceration, low education, and limited sexual networks. The combination of increased STD incidence, low testing rates, and chronic barriers such as racism, homophobia, and HIV stigma may be the primary culprits. Thus there is a great need for increased HIV testing, linkage to and retention in care, and adherence to treatment for Black MSM.

Attempts to change sexual behavior (our most primal behavior) face a daunting challenge. The history of the AIDS epidemic and the many prevention efforts of the last 30 years illustrate how difficult that challenge can be.

Stephen Karpiak is Senior Director for Research at ACRIA.
write this to honor the memory of my friend and brother Victor Pond, who was senselessly robbed of his life by a group of despicable, selfish, raging idiots who prey on ailing members of the HIV community. A group that essentially murders vulnerable individuals who are in search of acceptance from society, family, and the religious communities to which they dedicated their lives.

Victor was a devout Christian from birth until death. He served faithfully for many years in his native Panama, and continued that commitment in the U.S. He served, taught, tithed, and ministered in song, oft-times without compensation. A trained lyric tenor, he had the ability to sing in every musical genre and so was in high demand. He graced many recording sessions, sang jingles, and toured with several theatrical productions and artists. He was also a gifted chef and pastry artist. We ran a catering company together for 15 years in New York City before he moved to Chicago, where he worked as a counselor/social worker. He was passionate about his work in the HIV community and was determined to spread the word about the recent medical advancements. He sought to educate the community and inform them about the services available to anyone affected with the disease.

But Victor struggled with a lack of acceptance from his church and other circles, but was determined to live his life openly and without repression. This was not acceptable in his church. When he returned to New York City a few years ago, he was diagnosed with AIDS, but there was hope. He was excited about starting the new HIV treatments and was doing quite well. His health improved, he found a new job, a new apartment, and a new church in Harlem. Everything was great, except for the acceptance challenges he faced within his church.

Victor was an activist to his core – he was born that way. He loathed injustice and intolerance on any level and was vocal and determined to effect change. But change was a foreign concept to his church. They stood firm in their beliefs. So Victor paid a huge emotional price for his choices. His church community left him broken-hearted and searching until he found what he so desperately needed – emotional acceptance and support – offered by HIV denialists. They know that there are many within church communities in need of an emotional embrace.

It started with heated online debates where HIV denialists offered research and alternatives to mainstream HIV treatment. Victor spoke to friends and colleagues, who advised against following the recommendations made by the denialists. Then one day about two years ago, he came to me and announced that after much research he was going to try juicing and other alternative options that included veganism.

I cautioned Victor against this. What I didn’t realize is that the denialists understand how to acquire information that helped them push their agenda. They work with their victims to help them convince family and friends to accept their decision to stop HIV treatment. I have been a vegan for over 30 years and understand the benefits of holistic healing. But one must be wise, have realistic expectations, and understand that there are times when mainstream medicine is the best choice.

I also work in the medical community and know for a fact there are wonderful advancements in medicine that have proven results in people with HIV. The current medications, in addition to a healthy diet and exercise, are helping many people with HIV live long, productive lives. This is not the AZT of years ago that indeed had a negative effect on the body. The medical approach is different these days. There has to be

continued on next page

by Verania Kenton
a partnership between the medicine and lifestyle. It is naive for anyone to think that juicing, a vegan diet, and the other alternative approaches promoted by HIV denialists will cure HIV or any AIDS-related disease.

Unfortunately, Victor followed the advice of the denialists and ended up in the hospital with pneumonia in 2013. He got treatment that instantly improved his health, with minimal side effects. So he went back on his HIV medications. But a few months later, the denialists convinced him that the pneumonia was just the body’s natural response to the detoxification process and that he should be patient. Victor was convinced to try their method again.

Remember, these are HIV-negative people giving medical advice to HIV-positive people.

Victor ended up in the hospital again, and asked me to contact his church. I called the pastor. No visit, no prayers for this member. Shameful indeed. Victor’s health deteriorated – he slipped into a coma and was placed on life support. This lasted several months and we were informed that Victor’s chances of survival were slim. At the request of a family member, I again reached out to the church and spoke with the pastor, who informed me that he “wasn’t sure his schedule could accommodate a visit”. He didn’t come or even call Victor’s family. Not another word. Finally, a nurse who worked at the hospital recognized Victor from his church and had a few deacons come and give him communion and pray for him while he was in the coma.

Victor’s hospital stay over the next few months included aggressive treatment that saved his life. He survived, but had a long road ahead of him. The illness had wreaked havoc on his body. His doctors prescribed medications that would help him recover, but he would need assistance. So he moved to Virginia to live with his family, where he did well for months. He was up and about again, walking around and living.

Then he made a fatal mistake. He resumed correspondence and conversations with the denialists. It took months, but they managed to find a way in. Victor was lonely and slightly depressed, ailing and broken-hearted. He missed his friends and extended family and resented having to leave New York. The denialists offered what seemed like a logical remedy that would help him recover quickly and return to New York, cured of all ailments. They were relentless, and as Victor’s body failed and his mind weakened, they finished the job.

The denialists use a type of negative mind conditioning that is effective on individuals rejected by their chosen belief system. It further alienates, damages, and destroys so many souls like Victor, people who are very susceptible to victimization. The HIV denialists seek out the “Victors” of the world and offers them a false embrace – a lethal embrace that costs these gems their lives. They convince their victims that AIDS doesn’t exist, that they are not sick, and that HIV meds, not the virus, are harmful.

The negative attacks, manipulation, and other measures that HIV denialists offer are a sham. The approaches they recommend, do not work. They neither heal nor cure. In fact, their system kills every person who follows it. It weakens the body and diminishes its ability to fight the illnesses that come with AIDS. The only guaranteed outcome for anyone who follows their advice is a health breakdown, organ failure, and death. They must not be allowed to continue to infect these victims with their false “truths”, which are essentially murder!

The HIV denialists seek out the “Victors” of the world and offer them a lethal embrace that costs these gems their lives. They convince their victims that AIDS doesn’t exist, that they are not sick, and that HIV meds, not the virus, are harmful.

I miss Victor terribly. I can’t deny that this is deeply personal for me. It was emotionally expensive for me to compose these words. How does one describe how such a beautiful soul has impacted her life? There are not enough words to describe all the positive contributions this amazing person made in my life and the lives of so many. Victor had the capacity to understand, love, and forgive unconditionally – to make you smile from the inside out.

There is an emptiness inside me that is difficult to explain. Parts of me were lost when my closest friend/brother of 32 years left this earth…part of the gem in me was lost when he died. Sometimes I feel anger and other times deep sorrow as I try to make sense of a senseless death. Sometimes I feel a sense of guilt for not being able to love Victor enough and save him from this group. Why couldn’t I fix this? I should have been able to stop this, and I tried, as did many coworkers and friends. But we all failed.

In reality, the blame does not rest with us, for we too are victims of the HIV denialists. Fixing this will require a more powerful source than “I” or “self”. It requires “we” or “us”, uniting to eradicate a destructive group that moves in the shadows of the internet. “We” are the positive and powerful force that can bring about change! Those who loved Victor and those who love gems like him are left with the difficult, though not impossible, task of informing others about the work of the denialists and the hundreds of human carcasses left behind as a result of their evil manipulation and conditioning. The mass murders must stop! Our gems are precious, valuable souls. Not another soul lost. It stops…now!

Submitted in loving memory of Victor Pond.
Fact vs. Fiction

It would be so much easier if we could simply tell people to use condoms, if they agreed that they were important, and if they used them correctly every time they had sex. We could end both the sexual transmission of HIV and the AIDS epidemic tomorrow, much less by 2020. But as discussed in the articles in this issue, it’s not that easy.

Humans are complex beings – a combination of mind, body, and spirit. And when two or more of us get together, we have not just one person’s perception of risk to contend with, but at least two. We filter information through our life experience, and those filters can allow us to grasp the clarity of facts or create personal fictions. Sometimes we do a little of both.

Helping people protect themselves with proven HIV prevention techniques has been challenging. But with infection rates rising among young MSM – especially young MSM of color – we clearly have a long way to go. There’s no secret tool or technique to get, to help, to make, to motivate, to push, to convince, people to protect themselves. Sexual risk reduction means that behaviors must be changed not just one time but consistently over time. In the three decades of the AIDS epidemic, prevention workers have learned that they can’t make people do what they don’t want or aren’t able to do.

As human beings, whether gay, bisexual, or straight, we have wonderfully inventive ways to rationalize the amount of HIV risk we’ll allow into our lives. And because our lives are not static, the amount of risk we accept changes as our world and relationships, and our facts and fictions, change. Poverty, access to health care, racism, sexism, homophobia, transphobia, ageism, and AIDS phobia all factor into the filters we use to perceive our risk.

Some practice safer sex, are able to protect themselves, and so don’t worry about HIV. Some consider their risks, but based on faulty evidence – such as being told of a negative HIV test or making assumptions based on a partner’s healthy appearance – feel safe enough not to use that condom. Some are worried about HIV but don’t protect themselves because they want to please a partner who doesn’t want to use a condom. Some practice “survival sex”, which requires condomless sex in exchange for a place to live. And some are not worried about risk at all because they don’t see HIV as a widespread problem in their community.

MSM today are meeting for sex in very different ways from those used when HIV prevention messaging was created. Rather than meeting in bars, bathhouses, or sex clubs – where HIV prevention messaging could be widely seen – most are now meeting partners online or through apps like Grindr. And safer sex is often replaced by aggressive interrogation: “Are you clean?” “When was your last HIV test?” “How often are you tested?” “Do you always play safe?”

If the “correct” answers are given, the condom is dispensed with, since the person is deemed “safe” for barebacking. But studies have estimated that up to half of all new infections come from people unaware of their HIV status, and this is playing a large role in the recent increase in HIV infection in young MSM.

There are some things we know about how people perceive their HIV risk:
1. They tend to underestimate their actual risk for HIV.
2. They may know they are at risk but be unable to protect themselves.
3. Knowledge of risk alone doesn’t change behavior.

So if we want to end AIDS by 2020, our prevention efforts must do more than just deliver cold, hard facts. We must address people’s inability to separate those facts from fiction. We need a larger list of interventions with proven effectiveness – in other words, an “evidence base” of success. You might think the CDC is overflowing with such evidence-based interventions for MSM, or young MSM, or young MSM of color, but sadly it is not.

The CDC’s Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention lists 81 interventions, of which only eight are targeted specifically to MSM. There are 39 targeted at heterosexual adults. Of the MSM-specific interventions, four were developed in the 1990s and four between 2000 and 2006.

Our prevention toolbox must include both biomedical and effective behavioral interventions. Biomedical interventions such as PEP, PrEP, and “Treatment as Prevention” can all serve to lower community viral load. But we cannot lose sight of the continuing need for behavioral interventions that are timely and targeted. These interventions must make use of both old and new communication methods, social media, and mass media, addressing not only prevention but also stigma. Unfortunately, stigma is alive and well and still creating barriers to HIV testing and care. Finally, we need technical assistance to get these interventions up and running consistent with the key elements of the intervention so that program staff walk in line with the evidence base.

Only such a multipronged approach to HIV prevention will ever have a chance to actually end the AIDS epidemic.
Newly Diagnosed?
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**Living with HIV**

workshops, designed for people with HIV who want to learn more about how to manage their HIV.

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