Reducing the risk of HIV in gay and bisexual men

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There is a continual increase in the incidence of HIV in the UK. This article looks at strategies that can be used by specialist health promotion nurses to meet the need for increased awareness among gay and bisexual men of the importance of maintaining safer sex in their relationships.

Figures recently released by the Health Protection Agency (2004) show that an estimated 53,000 adults were living with HIV in the UK at the end of 2003, of whom 14,300 were unaware of their infection. In 2003, there were 6,780 new diagnoses of HIV, contributing to a total of 66,554 since the epidemic began. As of September 2004, there have been 20,778 diagnoses of Aids in the UK. At least 13,033 of these people have died.

In February 2004 a headline in The Guardian read ‘HIV “here to stay” as new cases rise 20%’. Dr Barry Evans wrote that an increase in people practise unsafe sex was behind the increases (Boseley, 2004). Martin (1995) warned that this may happen if HIV/AIDS education was not targeted at the people affected by it and underlined the need for nurses, in particular, to be informed and involved in the education process. This is clearly still relevant today as the numbers begin to rise.

The extent of the problem

A survey carried out in the mid-1990s (Hickson et al, 1996) came to the conclusion that despite an increase in prevention targeted at gay men, aggregate levels of risk-taking had remained very stable. As a result, reassessment of the efficiency of current HIV-prevention messages and methods with gay and bisexual men is urgently required.

Of the sample in this research, one in three men had engaged in anal intercourse without a condom with at least one male partner in the preceding year and one in ten with multiple partners. In fact there is evidence of a phenomenon among gay men called ‘barebacking’ (Wells, 2000), which involves actively seeking anal sex without a condom for added excitement.

A further project carried out for the Health Education Authority (Weatherburn and Reid, 1995), which looked at the behaviour of bisexual men, showed that the numbers not using condoms were higher than for gay men. A total of 699 men reported vaginal intercourse, of which 502 had not used a condom (72 per cent) and 461 reported anal intercourse with a male partner, of whom 135 had not used a condom (29 per cent).

These studies, in the mid-1990s, paint a frightening picture, confirmed by the more recent figures (Keogh et al, 2000) where it was found that 11.5 per cent of men using anonymous sex sites (cruising grounds, saunas, pubs and clubs) had anal intercourse without a condom. Surprisingly, this was more common among men who had tested HIV positive, although these findings are not in line with studies in the US, which appear to show a different pattern (Nimmons and Folkman, 1999).

Coupled with the rise in syphilis among gay men – particularly in Manchester, London and Brighton, which have high profile-gay communities – the statistics show a worrying trend. In Manchester there were 160 cases of syphilis in 2001 (Boseley, 2002), around three-quarters of which occurred in young gay or bisexual men.

The potential effects of highly active antiretroviral therapy (HAART) on sexual behaviour have not yet been fully researched. The fear is that people with no free HIV detected in their blood may believe, erroneously, that they cannot transmit the virus and so engage in unsafe sex (Pomerantz, 1999). Similarly, uninfected men who assume that the therapy has led to a more optimistic prognosis may begin to take risks (Elford et al, 2000).

A major problem in the past has been that the media and sex educators have shied away from talking about anal sex but it is clear that for many gay men this activity is central to their sexual behaviour (McKenna, 1995). It is clearly not enough to say ‘use a condom’ as many find them uncomfortable and desensitising. What is needed is a new approach that acknowledges the difficulties surrounding access to the culture and the sensibilities of the people who are at risk.

The way forward

Martin (1995) advocated targeted HIV/AIDS education as the way forward. He showed that when HIV health education ceased to be targeted at gay men the incidence of sexually transmitted diseases...
increased in that group by 15 per cent on the previous year. In the light of this, Martin suggests that nurses involved in the care of people with HIV/AIDS need to be fully informed and able to give safer sex information and advice to their clients. This does not, however, go far enough. The educators may be better informed, but it is clearly the medium rather than the message that needs to be addressed. In this paper, four routes of health promotion will be explored:

- The traditional outreach intervention model;
- Peer-driven intervention based around a network model;
- The same-age buddies model;
- One-to-one intervention by health professionals using a cognitive approach.

These routes are based on those recommended by the Evidence for Policy and Practice Centre review (1996).

**BOX 1: RECOMMENDATIONS FOR DEVELOPING SAFER SEX STRATEGIES**

- The empowerment of clients must be paramount. They should be enabled to take control over safer sex strategies in their everyday lives, whether they are HIV positive or not.
- A clear plan should be developed, based on a full assessment of individual needs and the facilities available in the local area.
- Full collaborative working with the representatives of all relevant organisations and the men whose behaviour the health promotion is designed to address.
- Development of interventions that include, as a core feature, the development of interpersonal skills.
- Consideration of community-level and small-group interventions to foster a supportive and multi-agency approach.
- Ideally, gay community nurses with knowledge of the local culture should be centrally involved.
- The advantages and disadvantages of each model of intervention should be considered as part of the assessment process, taking into account levels of funding necessary and the best approach for the particular client group.
- Ongoing evaluation of interventions should be carried out to ensure that the agreed approach is effective.

**Traditional outreach intervention model**

Prout and Deverell (1995) reported a number of UK projects, many run by local groups of MESMAC (Men who have sex with men — action in the community) such as a Leicester group’s work in local saunas and projects run by MESMAC North East Groups in Sheffield, Glasgow and Southampton are also active. There have also been projects carried out by Tyneside Gay Men’s Youth Group and Leeds Lesbian and Gay Theatre Group. Unfortunately, there has been little attempt to measure the effectiveness of these initiatives. Some research has been done into projects for raising awareness, concluding that an increase in safer sex behaviour was evident (Prout and Deverell, 1995). However, changes in behaviour were found to be inconsistent and difficult to maintain. The Evidence for Policy and Practice Centre (1996) came to the conclusion that these programmes have not been evaluated effectively for evidence that they lead to behavioural change.

**Peer-driven intervention**

Broadhead et al (1998) produced results from a peer-driven intervention among injecting drug users (IDUs). The project was based around a social network model of peer intervention and this was compared with a traditional outreach intervention model. The approach contained four elements:

- Recruiting IDUs for the project at the ‘storefront’ (the drop-in centre);
- Educating IDUs in the community;
- Relocating IDUs for follow-up/further education;
- Distributing risk-reduction materials such as bleach and condoms.

In addition, the IDUs were given guidance about infection control (not just safer sex) and monetary rewards to disseminate this information among their own drug-using networks. The findings showed that this kind of direct collaboration with active drug users was effective in reducing IDUs’ risk behaviour (Broadhead et al, 1998).

It was found to be better than the traditional outreach intervention model, which suffered from a host of organisational problems that led to stagnation and poor performance by outreach workers. According to the researchers, the peer-driven intervention approach resulted in an increase in the number and range of people recruited to the project compared with traditional outreach.

They point out that research has generally shown that unsafe sex is a behaviour that is resistant to change. The traditional outreach intervention produced a 42 per cent reduction in unsafe sex among IDUs, but the peer-driven intervention produced only a 20 per cent reduction in one geographical area. This low figure was put down to the fact that the better results were achieved by the group who

**REFERENCES**

**Evidence for Policy and Practice Centre (1996) Review of Effectiveness of Health Promotion Interventions for Men who have Sex with Men. London: University of London.**


This article has been double-blind peer-reviewed.

For related articles on this subject and links to relevant websites see www.nursingtimes.net
were located nearer to the ‘storefront’ or drop-in centre, as they were able to obtain support or collect condoms, leaflets or clean intravenous drug equipment quickly.

Broadhead et al (1998) conclude that peer-driven intervention provides everyone with the opportunity to serve as a peer educator, allowing for greater self-esteem and self-efficacy. However, the results cannot automatically be applied to gay and bisexual men.

Kegeles et al (1996) have developed a similar peer-driven intervention programme with young gay and bisexual men in the US. They employed a variety of social, outreach and small-group activities. The authors judged the intervention to be effective, with unprotected anal intercourse being reduced. However, high attrition rates may raise doubts about these conclusions.

**Same-age buddies model**

Seal et al (2000) reviewed the literature and found that it was younger men who were most at risk, particularly those between the ages of 15 and 25 (McAuliffe et al, 1999). They went on to ask this age group what kind of support they felt they needed. The work was done in the US and any discussion of the results needs to take this into account, as the culture for gay men in the UK is different.

The researchers conducted 72 interviews lasting about 90 minutes each. They found that most of the men did not mention HIV-specific programme content, indicating a strong need for comprehensive sexuality programmes that addressed issues such as dating, relationships, intimacy and feelings of love. They also stressed the importance of psychosocial factors such as low self-esteem, a lack of self-care and self-love, depression and teenage suicide.

They felt that the ‘free love’ culture of the gay community put pressure on them to conform and this conflicted with their need for emotional attachment. They found it difficult to find emotional intimacy in the gay community.

One important lesson that arose from the research was that the ‘just say no’ message was not the answer and that HIV prevention programmes needed to move beyond the ideology of abstinence to the management of sexual arousal and the promotion of healthy sexual choices. There was a need to focus on strategies for negotiating safer sex when using drugs and alcohol because bars and raves were central to the social fabric of the gay community.

The gay community is diverse and so approaches to safer sex education need to be different for different sections of the community. Suggestions included one-on-one education, mentoring and role modelling, social events, small workshops, and social marketing campaigns. Respondents felt that such programmes needed to be ‘fun’ and conducted in a comfortable atmosphere.

The main themes that arose were:

- The need for programmes that addressed social, psychological, interpersonal and cultural issues, rather than basic HIV risk education. Rotheram-Borus et al (1994) support this;
- Peers and same-age buddies should be centrally involved in such programmes;
- There was suspicion of the role of older gay men in the programme but it was agreed that they had experience that was a valuable resource, particularly as role models;
- The need for a ‘safe space’ to escape the general homophobia of the ‘straight’ community.

This research could be applied to the situation in the UK, particularly in urban areas where there tends to be a higher concentration of young gay men. However, comparisons with the situation in the US need to be treated with caution as the laws and social structures of the two countries are often quite different. For example, there has been a long history in the US of legal sexual activity in private that is only just being allowed under the law in the UK. It should be noted that until such approaches have been tested and evaluated it is not possible to say that they are effective.

Mutchler (2000) used a similar approach to Seal et al (2000), undertaking 20 interviews with young gay and bisexual men as well as observing their interactions in a social setting. In addition, there were a total of four further interviews with community project managers.

Mutchler rejects what he calls the ‘traditional self-empowerment model’. This model is focused around educators who provide information through one-to-one contact in bars and public sex environments. Mutchler advocates a ‘community empowerment model’ where people, working together, act on environmental and community-based factors that affect their behaviour. Mutchler recommends a gay-positive space where peer support and social and educational activities can take place, similar but somewhat broader than Seal et al’s (2000) buddy system.

There are clearly several difficulties when trying to apply this approach. The first is finance. It is difficult to obtain funds for long-term projects in the UK, so the strategy may be impractical as a first-line approach.

A further problem is access to the men who are most at risk. Joseph et al (1991) make it clear that such gay networks, even those of a less formal nature, may be instrumental in reducing risky sexual activity. However, a large proportion of the men engaging in such activity may not want to be
involved in community projects of this type where they have to face a certain level of ‘coming out’. Mutchler (2000) points out that individuals from such projects should work together to reach their isolated and disempowered peers in the gay and bisexual community.

One-to-one intervention
Gold (2000) looks more closely at the thinking that results in unprotected anal intercourse and attempts to plan one-to-one cognitive interventions to encourage changes in behaviour. DiFrancesco et al (1999) felt that personality traits that determine a person’s commitment to behavioural change and tendencies for risk-taking need to be considered when designing long-term interventions.

Gold (2000) started with the premise that men who engage in unsafe sex do so despite knowing the risks and justify their decision to themselves at the time that they make it. To change this pattern of behaviour it is necessary therefore to make contact with the reasoning that is present during actual sexual encounters.

In an effort to do this Gold asked gay men to reflect on and evaluate, in the ‘cold light of day’, the thinking they had used in the heat of the moment. It was hoped that this would meet the aims outlined by Nimmons and Folkman (1999) and bolster the men’s resolve to practise safer sex, clarify their values or remind them why safety mattered. A key factor necessary for this approach to work is that the men have to want to change their behaviour.

Gold came to the conclusion that in these circumstances HIV prevention educators can exploit the difference between men’s thinking in the ‘cold light of day’ and in the ‘heat of the moment’ to promote changes in behaviour. Men on the programme were asked to keep diaries, in accordance with guidelines supplied by the project, and to record what was in their minds when they ‘slipped up’. As a consequence they were able to reduce the incidence of multiple slip-ups in the post-intervention phase. The number was significantly lower than that of a control group who did not receive the interventions.

Gold’s research does not provide any exact figures and therefore this approach to safer sex promotion needs to be considered with a measure of scepticism.

There are clearly problems with any kind of research process that makes judgements about appropriate sexual behaviour. It may be that such an approach could work with individual men who habitually practise unsafe sex, but it may prove to be impractical when applied to larger numbers of gay and bisexual men over a broad geographical area.

Application to nursing practice
Research has shown that community involvement reduces sexual risk behaviour through its effects on four mediating factors (Ramirez-Valles, 2002):
- Peer norms;
- Self-efficiency;
- Positive self-image;
- Alienation.

The strategies from the literature could therefore be applied to the community environment in a realistic and productive way in an effort to identify ways forward.

There have been a number of UK studies that address the area of HIV health education, mainly from the London-based Sigma Research and the CHAPS (Community HIV/AIDS Prevention Strategy) development project. These projects have looked at a number of health promotion interventions, for example assertiveness training (Hickson and Boxford, 1999), establishing principles for the rights of gay men with HIV (Ward, 2001) and reflection on how HIV prevention work brings about change (Bonell et al, 2000).

It is important to take on board the guidelines from Ward (2001), particularly regarding the need to ensure the involvement of gay men with HIV in the whole process of health promotion. There is also the need to cover a wide range of intervention topics to account for the diversity of the gay community, such as assertiveness training (Hickson and Boxford, 1999), relationship exploration and interpersonal skills.

Conclusion
It is clear that despite the fact that some men employ risk-reduction strategies, they may not use condoms consistently. Hickson et al (2000) emphasise the need to allow people to take control over HIV in their everyday lives, whether they are HIV positive or negative. They highlight the importance of implementing a clear plan that meets the needs of the local area and evaluating interventions to ensure that they have been effective. All this must be a collaborative effort between the representatives of gay and other organisations and the men whose behaviour the health promotion is designed to address.

Johnson et al (2002) came to the conclusion that interventions featuring the development of interpersonal skills were the most effective at promoting safer sex, but that community-level and small-group interventions also showed favourable results in preventing HIV infection.

Ideally, for initiatives that arise from the health service, community nurses who are themselves gay and who have knowledge of the local culture, are best-placed to carry out this type of health promotion activity.

REFERENCES


