EDITORIALS

When Plagues Don't End

Writing in the middle of the last century, Albert Camus brilliantly illustrated that, in times of plague, no shortage exists of those who confidently proffer nostrums, no matter how spurious. *The Plague*[1] also depicted how quickly, when crises abate, memory fades.

These are apt themes for this issue of the Journal. Rather than celebrating improved control of HIV in the United States, and turning to the advancing pandemic elsewhere, we pause in this issue to recognize that in the United States the threat resumes among men who have sex with men (MSM). Among one of the most marginalized segments of that population, young Black MSM, HIV spreads at rates considered devastating when reported from other nations. The preventive nostrums we depended on—community mobilization to address the threat; virtually ubiquitous, free, confidential, and anonymous HIV counseling and testing; and, eventually, very effective treatment—no longer work. Did they ever "work"?

To prevent HIV transmission, we have little more today than we had 2 decades ago, when it became clear that the virus causing AIDS is sexually transmitted: behavioral interventions. Daniel Ciccarone and colleagues[2] suggest that the prevention ethos prevalent in the gay community—assume your partner is HIV infected, absent evidence to the contrary, and act accordingly—may have had the unintended consequence of discouraging disclosure of HIV status and assumption of mutual responsibility for determining the need to use a condom.

So impressive were reductions in HIV incidence rates in the mainstream gay community between the mid-1980s and late 1990s that attention shifted to other marginalized populations. We never measured what kind and how much of an intervention would be needed to effect and sustain measurable reductions in HIV transmission among MSM. It's as if vaccines that looked good in the laboratory were never tested for efficacy in preventing infection but, instead, were erratically and indolently delivered to at-risk communities, without follow-up studies to see how long any benefits would last before a booster dose might be needed.

One important exception was a study designed and initiated, paradoxically and fortuitously, when HIV incidence among US MSM reached its nadir. EXPLORE, a randomized, controlled clinical trial sponsored by the National Institutes of Health, had, as its primary aim, the direct measurement of the impact of a robust behavioral intervention on HIV incidence in a large cohort of HIV-seronegative US MSM. It draws to a close as this issue of the Journal goes to press, with its principal outcomes anticipated by late 2003. Nearly 4300 MSM in 6 US cities—at continuing risk of exposure, as profiled by Beryl Koblin and colleagues[3]—received either an intensive prevention counseling program or an idealized version of "standard care"—that is, a rigorously quality-controlled implementation of semiannual HIV counseling and testing, based on guidelines developed and promulgated by the Centers for Disease Control and Prevention (CDC).

The EXPLORE behavioral intervention provided 10 one-to-one sessions, 45 to 60 minutes long, with a trained, supervised counselor, during the first 4 to 6 months of study participation, followed by quarterly "maintenance" visits. Themes and counseling methods shown by previous research to be salient to MSM risk behavior were synthesized in a design that sought to balance flexibility with reproducibility. Counseling sessions were designed to accommodate the specifics of a participant's life situation within a prescribed, manual-driven framework. Margaret Chesney and colleagues[4] indicate that the content and methods of the behavioral intervention correlate with factors that predict risk behavior among MSM in the study, and that an individualized intervention corresponds with highly heterogeneous clustering of those factors among study participants.

Although the counseling program in EXPLORE provides what is probably the most robust counseling program imaginable for large-scale implementation, it was not feasible to embed in such a program formal treatment for intractable, underlying problems that have been known for a decade or longer to be more prevalent among MSM than otherwise comparable heterosexual populations. Yet these problems

seem to make risk reduction particularly problematic for a substantial fraction of MSM. They include depression, persistent problem drinking, high prevalence of recreational drug intake, including polydrug use, and adult sequelae of exposure to childhood sexual abuse.

The important new concept suggested by Ron Stall and colleagues[5] is that these conditions often co-occur in the same individual and, in those circumstances, are synergistic in conditioning difficulties with the adoption and consistent practice of safer sex. Certainly, a just and comprehensive concept of health would identify these disparities as important concerns in their own right. Their association with HIV makes the development, evaluation, and dissemination of effective diagnostic and treatment strategies all the more urgent a public health priority. David Malebranche[6] reminds us that, as much as we may have learned about predictors of transmission in predominantly White MSM communities, our understanding of HIV among racial and ethnic MSM subgroups remains primitive, desperate for innovative research and intervention approaches.

A rapid assessment methodology that characterizes microenvironments important for HIV transmission, described by Richard Needle and colleagues,[7] is promising for pinpointing milieus in which risky behaviors cluster, and also troubling. Interventions, such as they are—furtive sex stalkers and drug dealers temporarily scattered by the beam of a patrol car searchlight—fail to keep pace with the epiphenomena of transmission. Now we better understand—who doubted it?—that sex and drug exchanges occur outside the daytime office hours kept by prevention project staff, and that risky behaviors do not segregate across the arbitrary turf carved out by disparate public programs.

Heralding the threat of a resurgent HIV epidemic, the CDC noted 2 years ago that MSM, especially young MSM and MSM of color, were overrepresented among Americans with HIV, yet underrepresented in intervention research.[8] As elaborated in this month's "Going Public" feature,[9] we need new biomedical technologies as well as rigorous assessment and effective translation and dissemination of behavioral approaches that never were adequately developed and implemented in the first place to address the prevention needs of MSM. Perhaps most important, somehow we need to immunize prevention science, programs, and policies against stigma, political opportunism, and sanctimony. ■

Michael Gross, PhD

About the Author

The author is the Journal's associate editor for HIV/AIDS and lesbian-gay-bisexual-transgender health.

Requests for reprints should be sent to Michael Gross, PhD, 1601 18th St NW, #716, Washington DC 20009 (e-mail: m144@earthlink.net).

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