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Sexually transmitted diseases and HIV infection among homosexual men

EDITOR,—B G Evans and colleagues conclude the discussion of their paper by stating, "Because of the high background prevalence of HIV-1 infection risks to homosexual men practising unsafe sex are greatest in London."[1] They further suggest that "safe sex information aimed at . . . homosexual men in London needs special emphasis."

This statement might be misunderstood by readers to imply that unsafe sex elsewhere is somehow less risky than it is in London. This is certainly untrue of Brighton, where the high prevalence of HIV-1 infection in homosexual men is similar to that in London. Indeed, the rate of infection in Brighton is probably the highest in Britain (90 new infections in homosexual men reported in 1992 (23% of those tested)). By any statistical configuration, the concentration of HIV infected homosexual men in Brighton is higher than that in London or elsewhere in Britain. The chance of infection through unsafe sex in Brighton is therefore relatively higher.

Information on safe sex aimed at homosexual men in Brighton is needed. Statutory and voluntary organisations have recently intensified education and information programmes and increased the educational involvement of outreach groups with homosexual men in Brighton.

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1 Evans BG, Catchpole M, Heptonstall J, Mortimer J, McCarrigle C, Nicoll A, *et al.* Sexually transmitted diseases and HIV-1 infection among homosexual men in England and Wales. *BMJ* 1993;306:426-8. (13 February.)

EDITOR,—We have conducted a similar study to that of B G Evans and colleagues of sexually transmitted diseases and HIV-1 infection among homosexual men in England and Wales.[1] Our results reinforce their findings to a certain extent, but our experience in 1992 shows a further reduction in new cases of gonorrhoea in men and in the diagnosis of HIV positivity in male homosexuals.

We looked at the total incidence of gonorrhoea; the number of cases of gonorrhoea found in men overall and in homosexual men; the male to female ratio of cases of gonorrhoea; and the number of new cases of HIV infection diagnosed in homosexual men (table). Like Evans and colleagues, we found that new cases of gonorrhoea in all men and in homosexual men showed an increase in 1988-90. Our study, however, showed a reduction in 1991 and 1992. The male to female ratio of cases was lowest (1·2:1) in 1987, subsequently rising to 2·1:1 in 1990. The number of new cases of gonorrhoea in homosexuals was lowest in 1987 and then gradually increased until 1990.

Our study indicates that unsafe sexual practice may have increased in men from 1987. The decline in gonorrhoea and other sexually transmitted diseases in the mid-1980s may have been due to safer sex practices after health education through the mass media and various other local activities. The reduction that we found in 1992, in both gonorrhoea and HIV infection, is heartening, but vigorous and continuing health promotion will be necessary to continue this trend.

Cases of newly diagnosed gonorrhoea and HIV infection, 1985-92

	1985	1986	1987	1988	1989	1990	1991	1992
Cases of gonorrhoea:								
Total	424	355	138	160	162	122	82	72
In men	268	203	76	98	96	82	52	47
In homosexual men (%)	49 (18)	13 (6)	4 (5)	8 (8)	11 (11)	24 (29)	13 (25)	6 (13)
Male:female ratio	1·7	1·3	1·2	1·6	1·5	2·1	1·7	1·9
Cases of HIV infection in homosexual men	27	24	16	17	18	18	21	14

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EDITOR,—B G Evans and colleagues present compelling evidence that unsafe sexual behaviour and transmission of HIV have increased among gay and bisexual men in England and Wales after a decline in the 1980s.[1] They suggest that this may partly be due to a failure to sustain the successful community based health education activities of the early and mid-1980s.[2-4]

To ascertain the level of HIV prevention activity specifically targeting gay or bisexual men in Britain, staff and volunteers at the National AIDS Manual, North West Thames Regional Health AuthoriGy HIV project, the Terrence Higgins Trust, and Gay Men Fighting AIDS undertook a survey between November 1991 and April 1992.[5] Two hundred and forty organisations with a remit for HIV prevention work were identified. Answers to a standard telephone questionnaire were obtained from 226 (94%); 202 respondents were statutory organisations and 24 were voluntary agencies.

Altogether 149 respondents reported that they had never undertaken or funded any HIV prevention work specifically aimed at gay or bisexual men. Of the remaining 77, only eight had ever offered a "substantial" programme of such work; this was a relatively unexacting definition, requiring only a written needs assessment and the employment of a whole time or part time worker with a specific remit for this work. Only three agencies had ever offered a "comprehensive" package of HIV prevention work for gay and bisexual men, defined as needs assessment, the production of local health education resources, one or more public education events, staff training, and the employment of a worker.

At a time when it is increasingly popular to search for complex explanations for continuing or increasing levels of unsafe sexual behaviour among gay and bisexual men the most obvious explanation —lack of continuing education about safer sex— must not be overlooked. Evans and colleagues' concern about the failure of AIDS educators to target gay and bisexual men is well founded: it seems that those most at risk from HIV have also been the most neglected in recent years. HIV prevention workers must ensure that they prioritise their work according to epidemiologically demonstrable need if the alarming trends in surveillance data on sexually transmitted diseases and HIV infection are to be arrested or reversed.

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EDITOR,—We recently highlighted an increase in unsafe sexual behaviour and transmission of HIV among homosexual men in England and Wales after a period of decline.[1] Our data included documented seroconversions to the end of 1991—that is, newly diagnosed HIV-1 infection in men for whom the year and month of a previous negative result of an HIV-1 test were available. The table summarises revised data, including the seroconversions reported during 1992. The number of reported seroconversions has risen steadily since 1986; the number of cases in which transmission of HIV-1 was known to have occurred during 1990-2 (157) was more than double the number recorded during 1987-9 (74).

Year of HIV-1 seroconversion in 503 homosexual men who had had negative test results, England and Wales

Year of last negative result	Year of first positive result							
	1985	1986	1987	1988	1989	1990	1991	1992
1985	16	22	11	5	4	2	3	7
1986		16	20	2	5	7	9	6
1987			15	7	13	17	10	9
1988				11	21	14	16	10
1989					7	27	15	19
1990						15	33	22
1991							21	42
1992								24
Total	16	38	46	25	50	82	107	139

Despite widespread recognition in 1991 of the unfavourable trends in sexually transmitted diseases among homosexual men[2-5] transmission of HIV during 1992 seems not to have declined but may have intensified further.

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