

BRIEFING PAPER

The History of the Syndemic of AIDS among Gay Men in the United States and the Failure of the Risk Reduction Strategy

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HIV/AIDS is no longer a major concern for the public in the United States. It doesn't even make the list, but the epidemic rolls on. In 2014, the CDC estimated that 36,138 men were newly infected with human immunodeficiency virus (HIV). Of these, 30,635 (83%) were gay men or men who had sex with men (MSM).¹ While new infections in other categories have been declining, the category MSM has been increasing.

Why? Because from its inception the Risk Reduction strategy adopted to fight the epidemic was guided by, and today continues to be guided by, the political agenda of AIDS activists and not experts in public health. AIDS activists have been selling a failed strategy all along and using the HIV/AIDS crisis to sell their sexual agenda, which includes social acceptance of homosexuality and prostitution, to the world.

Why was such a flawed strategy adopted? Why has this disease targeted gay men? Why have all efforts to reduce new HIV infections among MSM failed?

The Emergence of AIDS Among MSM

Sex between males has gone on in various cultures and periods, with different levels of social acceptance or condemnation and involving different types of behaviors. The modern gay rights movement is unique, in terms of the number of extreme behaviors, the multiple concurrent sexual partners, the reciprocal nature of the acts, and the use of sex-enhancing and mind-altering drugs.

The term *homosexual* was invented in 1869. *Gay* came into use in the 20th century. The CDC uses *men who have sex with men* (MSM) to include all men who engage in sexual acts with other men, whether or not they self-identify as homosexual or gay.

The "Gay Liberation" movement only officially began on June 18, 1969, when gay men and crossdressing patrons of the Stonewall Inn in the Greenwich Village section of New York City rioted during a police raid

on the establishment. But within a few years they were able to obtain key victories with reverberating social implications, including for the eventual design of the global HIV/AIDS response.

In 1973, gay activists used threats of disruption, blackmail, and other tactics of intimidation to pressure the American Psychiatric Association (APA) to remove homosexuality from its manual of disorders, although there was no research to support this change, and at the time a number of therapists were successfully treating men who wanted to be free of same-sex attraction. Other professional associations followed the APA's lead. This led to changes in how homosexuality was seen more broadly by society, and even in law.

Freed from legal harassment, gay culture was freed to focus on the glorification of promiscuity. Various establishments catered to the desires of liberated gay men, including elaborate bathhouses where, during a single visit, they could engage in extreme sexual behaviors with multiple partners.

In 1978, in his book *Faggots*, Larry Kramer, a gay writer, exposed the out-of-control promiscuous sex and recreational drug use among his friends, who were offended, not because the exposé was inaccurate, but because it was true.

This state of affairs led to an epidemic of sexually transmitted diseases. In addition to common sexually transmitted diseases (STDs), gay sex could spread hepatitis A, B, and C, cancer-causing human papillomavirus (HPV), and a group of diseases previously associated with fecal contamination. The infected frequented STD clinics and doctors specializing in these diseases. The gay men demanded a quick shot to solve the problem and put them “back into action.” The situation put the medical community on high alert.

Repeated infection and treatment can lead to the development of antibiotic resistance. Doctors' warnings of health risks were ignored. Public health officials were concerned that if an unknown, incurable pathogen entered this sexual network, the results could be devastating.² Their concern became alarm when AIDS surfaced.

In 1980, strange diseases began appearing among gay men in Los Angeles, San Francisco and New York. In June of 1981, *MMWR* (Morbidity and Mortality Weekly

Report) reported on the first cases of what would later be identified as acquired immune deficiency syndrome (AIDS). Soon the U.S. Centers for Disease Control and Prevention (CDC) were receiving reports of a variety of rare diseases linked to a total failure of the immune system. Many victims developed Kaposi's sarcoma, a rare cancer that was later identified as a separate disease caused by the Herpes 8 virus.

By February 2, 1983, 1,025 people had been diagnosed with AIDS and 394 had died. The researchers from the CDC had deduced that the disease was spread by bodily fluids and probably caused by a virus. They realized that once a person was infected it could be years before full-blown AIDS developed, but once infected, no one recovered. They noted that many of the first MSM AIDS patients frequented bathhouses and reported having hundreds, some even thousands, of sexual partners.

AIDS Activists Design the Early AIDS Response

In 1983, a group representing People Living with AIDS put forth the Denver Principles for dealing with the disease. The statement included a demand that the public “Not scapegoat people with AIDS, blame us for the epidemic or generalize about our lifestyles,” and that the infected had a right to “as full and satisfying sexual and emotional lives as anyone else.”

It should be noted that gay men had been warned about the dangers of sex with multiple concurrent partners, but, even as their friends were dying and the cause became clear, many did not change their behavior. Instead they demanded that any prevention strategy accommodate gay men's promiscuous multi-partnering behavior. Researchers who studied MSM behavior distinguished between primary and secondary (casual) partners, assuming that for MSM, promiscuity is the norm.

Gay AIDS activists took leadership positions in the campaign for research, care, and treatment; however, they rejected standard public health protocols used to prevent the spread of STDs. Privacy and preserving sexual freedom were priorities. Avoiding moralizing and blame became the guiding principles of AIDS

prevention. They fought to keep the bathhouses open. Rather than issue warnings designed to engender fear about the consequences of infection, the infected were treated as heroes, the dead as martyrs.

The early history of the epidemic was documented by Randy Shilts, a gay reporter for the San Francisco Chronicle who later died of AIDS, in his book *And The Band Played On*. He was critical of gay AIDS activists, who, “while insisting that ‘AIDS is not a gay disease,’ treated the epidemic almost solely as a gay disease, the private property of a community that would base public health policy on its own political terms.”³

The AIDS activists insisted ‘Safe Sex’ promotion was sufficient to control the epidemic. They promoted the ‘Condom Code’ to schoolchildren. AIDS education was supposed to protect children, but in fact was designed to promote the gay sexual liberation agenda and recruit vulnerable teens. Students were told that gays were born that way, couldn’t change, and were no different than other people, none of which is supported by scientific evidence or social science research.

At first, the strategy appeared to be succeeding. From 1985 to 1990, the number of new cases among gay men decreased significantly. While changes in behavior accounted for some of the decrease, **epidemic saturation** was responsible for most of it.

In a relatively static population, if more than half of the group is infected, the number of uninfected shrinks dramatically and those uninfected at this stage of the epidemic are probably the most cautious. New infections will necessarily decrease; the epidemic will burn itself out. In fact, by 1988, in a single cohort of gay men attending an STD clinic in San Francisco 73% were HIV positive.⁴ A decrease was inevitable.

Some gay men recognized that the decrease in number of new infections was not due to the success of the condom code, but the result of epidemic saturation. Gabriel Rotello, in his book *Sexual Ecology*, warned gay men that if they did not make radical changes in their behavior they would be facing an endless epidemic. Sadly, his prediction has come to pass. As time passed and young men entered gay lifestyles and more effective treatment turned HIV infection from a death sentence into a chronic disease, gay men returned to their previous behavior and new infections increased.

AIDS activists continued to act as if moral disapproval of homosexuality and homophobia were a greater risk than HIV. It should be noted that while there were some ugly incidents, the public was in general sympathetic to the terrible suffering of those dying of AIDS.

Larry Kramer, who had earlier exposed the promiscuity of his friends, actively worked to draw attention to the failure of governments and the gay community to respond appropriately to the epidemic. However, in a 2004 speech, he admitted gay men were killing one another with unprotected sex:⁵

Does it occur to you that we brought this plague of AIDS on ourselves?...You are still murdering each other ... in 1984, when we were told it definitely was a virus, this behavior turned murderous... deep down inside of us we knew what we were doing.

He then listed those he might have infected who had died.

SYNDEMIC

Despite well-funded and far-reaching campaigns to curb the spread of HIV/AIDS, especially among MSM, the infection rate continued to rise. Eventually, it became clear to a number of professionals working in the field that they were not facing a simple epidemic, but a syndemic of HIV/AIDS.

In 2003 an article by Ron Stall and associates presented evidence that prevention programs which focused on behavior change failed because they were facing not one, but a number of co-occurring epidemics, each of which reinforced the others— in other words, a *syndemic*.

Co-occurring epidemics among MSM included:

- » higher rates of psychological disorders,
- » depression,
- » suicidal ideation,
- » other STDs,
- » substance abuse,

- » party drugs,
- » sexual compulsivity,
- » sexual addiction,
- » domestic violence,
- » partner rape,
- » a history of childhood sexual abuse (CSA),

Each increases the negative effects of the others.⁶ The analysis of the body of research on AIDS among MSM found:

The connection among these epidemic health problems and HIV/AIDS is far more complex than a 1-to-1 relationship; rather it is the additive interplay of these health problems that magnifies the vulnerability of a population to serious health conditions such as HIV/AIDS.⁷

Psychological Disorders

In 1999, the first two of a growing number of large-sample, well designed studies were published refuting the claim that gay men were just as psychologically healthy as other men.⁸ “The association between mental health and HIV transmission risk (i.e., sexual risk and poor medication adherence) is well established.” It has been proposed that mental health treatment, including behavioral and pharmacologic interventions, could lead to reductions in HIV transmission risk behavior.⁹ Psychological disorders and depression can lead to poor decision-making. A gay man may view contracting HIV as way to be accepted by the ‘cool crowd’ or as a heroic form of suicide.

Childhood Sexual Abuse (CSA)

While they receive less attention than girls, boys who have been sexually abused are at increased risk for substance abuse, serious psychopathology, anger, aggressive behavior, poor self-esteem, self-blame, and interpersonal problems.¹⁰

MSM are more likely to have history of Child Sexual Abuse (CSA) and are at even greater risk of negative outcomes.¹¹ MSM with a history of CSA are more likely:

- » to have frequent casual male partners,
- » to have significantly greater frequency of unprotected sexual acts,¹²
- » to have sex while under the influence of alcohol or mind altering and sex related drugs,¹³
- » to contract multiple STDs,
- » to have exchanged sex for payment,¹⁴
- » to report unwanted sexual activity or violence since age 13,¹⁵
- » to become HIV positive.¹⁶

A study of men attending an STD clinic found that 49% reported a sexual abuse experience during childhood.¹⁷ While this percentage is high, the real percentage may be higher since men are often unwilling to admit a history of CSA.^{18,19}

While interventions to prevent HIV have limited success among MSM, it was hoped that a more intensive intervention would succeed. The EXPLORE Study was a 48-month-long intense behavioral intervention designed to discover if counseling could prevent HIV infection. The researchers found that a history of CSA predicted subsequent HIV infection. “Among participants reporting CSA, the EXPLORE intervention had no effect in reducing HIV infection rates.”²⁰

The safer sex messages, for example, may be missing the point for people whose lives have been complicated by sexual victimization. Social scientists have urged for early identification of children and adolescents who may have been sexually assaulted because of evidence that the earlier the child can begin recovery from this trauma, the better the prognosis for normal adult functioning.²¹

Prevention of child abuse and early treatment could avert these consequences.²² Sadly, gay activists are working to shut down therapy for children and adolescents, because treating the abuse could cause the patient to realize that they are not gay, lesbian, or transgendered.

CSA also perpetuates a cycle of violence, abuse, and victimization. MSM who were victims of abuse as children are more likely to be victimized by their partners as adults. MSM who have a history of CSA are more likely to have exchanged sex for payment.²³ A study of MSM found that 29% reported being coerced into unwanted sexual contact, 92% of these events involved unprotected anal intercourse. This leads to depression, lower self-esteem and repeated incidence of abuse. On the other hand, some of the victimized engaged in acts of violence against others.²⁴ Victims of CSA often begin drug use in their teens and this may lead to hustling and high risk sex.²⁵

Chemsex

Chemsex describes intentional sex by MSM under the influence of psychoactive drugs including mephedrone, GHB, GBL, and crystal meth. Users report better sex, reduced inhibition, and a feeling of instant rapport with sexual partners. They describe “losing days,” and not sleeping or eating for up to 72 hours.²⁶ The experience can become addictive.

MSM with a history of CSA are more likely to have substance abuse problems. In particular, MSM who use crystal meth are more likely to become HIV-positive. Meth use is also linked to other STDs, hepatitis A, B, and C, failure of adherence to HIV medication, and adverse psychological consequences. Among meth users, prevention messages fail to change behaviors. HIV-positive MSM who use meth “have a higher risk of cognitive impairment and a faster progression into AIDS.”²⁷

Venues

Elaborate circuit dance parties, where drugs and unsafe sex are common, and internet sites which facilitate hookups, have sustained the epidemic:

Circuit parties are weekend events of non-stop partying held in various cities. They were begun

to promote HIV/AIDS awareness and stimulate gay community building and cultural identity formation. They inadvertently manufacture a subculture characterized by polydrug consumption and unsafe sex, often with multiple partners.²⁸

As many as 25% of party patrons self-identify as HIV-positive. A survey of participants found that 95% reported using club drugs.²⁹ These sex-enhancing drugs include crack, cocaine, Ecstasy, amyl nitrate, crystal meth, and special K (ketamine).

In spite of the overdoses and unsafe sex, efforts to stop or contain circuit parties have failed. Their advocates argued that moralistic and demonizing legislation only drives such activities underground and may even exacerbate the risk contained within them.³⁰ It is difficult to see what could be riskier than bringing HIV-positive men together with HIV-negative men from around the country to consume drugs and engage in unprotected sex, with an average of seven partners per weekend.

The CDC suggested that “Some communities have considered policies for sex venues where methamphetamine users with high levels of sexual risk behavior may be more likely to come in contact with non-users or people at lower risk. These venues include bathhouses, sex clubs, circuit parties, and internet sites. Such policies include reducing hours of operation and development and enforcement of drug-free venues.”³¹ Given the profits such events bring and the power of gay activists, so far nothing has been done.

One would think that health professionals would warn MSM about the risks of their behavior. However, only recently, Dr. Paul Church, a urologist at Beth Israel Deaconess Medical Center in Boston, was fired because he voiced concerns about his hospital’s promotion of Gay Pride events, even though his concerns were based on the irrefutable medical evidence of health risks associated with gay male behavior.³²

The risks for MSM are real, and are not limited to HIV. Men who engage in sex with strangers, who buy or sell sex, who purchase illegal substances, who become drunk or high and walk around dangerous parts of town late at night, or drive under the influence, as those who frequent the venues described above, are at higher risk

of being attacked, hurting themselves and others, and even being jailed as a consequence of their behavior.

Highly Active Antiretroviral Therapy (HAART)

While the search for a vaccine or a cure for HIV has failed, highly active antiretroviral therapy (HAART) has turned HIV from a death sentence into a chronic manageable disease. HAART has also proved to be an effective tool for prevention. Administered at the first evidence of infection, it has prevented transmission between sero-discordant, heterosexual couples.

Since an HIV-positive person is more likely to infect others during the first 18 months after infection, it was hoped that identifying infections early and beginning treatment early could prevent infections. However, in Great Britain, when the number of HIV tests and persons receiving HAART increased dramatically, the number of new infections remained unchanged.³³

The latest research is discouraging and suggests that with HAART, the presence of the virus in the blood disappears, however, the virus remains in the semen, and anal sex continues to pose a high risk.³⁴

AIDS Exceptionalism

Standard public health strategies have been rejected by gay AIDS activists. Public health and political leaders were lobbied and bullied to adopt AIDS Exceptionalism, the theory that because the disease was striking gay men, standard strategies would not work.

In a 1997 article entitled “The AIDS Exception: Privacy vs. Public Health,” Chandler Burr wrote, “It’s time to stop granting civil rights’ to HIV—and to confront AIDS with more traditional tools of public health,”³⁵ The rejected standard tools included:

- » Mandatory routine testing of at risk groups, such as all persons with another STD,

- » Registering the infected by name,
- » Tracing all sexual contacts—to track the infection forward to the most recently infected,
- » Informing and testing all sexual partners,
- » Closing all venues where transmission is taking place – gay bathhouses, sex clubs, circuit parties, internet hookup sites, etc.,
- » Banning MSM and other persons from at-risk populations from donating blood,
- » Making sure the infected receive treatment and adhere to medication – failure to take medication faithfully could lead to the development of drug resistant strains of the virus,
- » Penalizing those who knowingly infect others. Publicizing their names would be a real threat. No one has the right to infect another person with a dangerous disease.

The defenders of AIDS Exceptionalism argued that the main victims were gay men and gay men were an oppressed class, therefore standard protocols wouldn’t work. The gay AIDS activists insisted that MSM are afraid of being outed and wouldn’t get tested if they weren’t assured of absolute anonymity, that contact tracing and partner notification wouldn’t work because gay men had sex with hundreds of strangers, and that venues where infection spread should remain open because they could be used to disseminate educational materials and closing them would drive the behavior underground.

Risk Reduction Strategies

Gay AIDS activists insisted that all educational materials should be “sex-positive.” The goal was for gay men to modify their behavior as little as possible. The commonsense idea that it was wrong for the infected to have sex with the uninfected or that the infected were at the least obligated to disclose their HIV status was not mentioned. Community solidarity should be maintained. Educational initiatives should not distinguish between HIV-positive gay men and

HIV-negative gay men.

Educational interventions designed to encourage safer sex were not without effect. A percentage of those enrolled changed their behavior. However, most were inconsistent condom users and after a few months, they reverted to old behaviors. Many, even those who were HIV-positive, continued to engage in unprotected sex.

Risk Reduction interventions were designed to reduce infections, not eliminate them; however, in some cases they failed to meet even this modest goal.

Contrary to expectation, a 2001 behavioral intervention actually increased the risk of acquiring a new sexually transmitted infection. Of the men who had not received the intervention, 21% caught at least one new STD, while 31% who received the intervention caught one or more STDs. The authors concluded: “This suggests that there is a potential for some behavioral interventions to do more harm than good.”³⁶

Therapy

Intense safe sex counseling programs have had limited effect. The number of HIV-positive MSM increases each year. Gay activists recruit teenagers to a lifestyle that leads to sexual addiction and disease. The media ignore the problem.

The gay community appears willing to accept disease as an unfortunate, but unavoidable, price for sexual liberation. They demand that science find a vaccine or cure or at least a treatment with few side effects, so that they can continue to pursue their sexual desires. Anyone who challenges them is a labeled homophobe.

The gay AIDS activists have not only thrown out proven strategies and sold a failed Risk Reduction strategy, they are pushing legislation to make therapy for same-sex attraction illegal.

Some gay men were not convinced. For example, Charles Bouley wondered what it would have been like “if HIV had really been treated like a disease and not just a political or social condition.”³⁷

Thirty-five years is long enough for this experiment. Risk Reduction and AIDS Exceptionalism have failed.

Standard public health strategies aggressively pursued could make a difference, but more can be done. There is another approach.

MSM weren't born that way. What has been broken can be fixed. Same-sex attraction can be prevented and treated. CSA can be prevented, identified, and treated.

It is long past time for us to throw out Risk Reduction and AIDS Exceptionalism, use standard public health protocols for containing this STD epidemic, and promote treatment of same-sex attraction and childhood sexual abuse.

If we do the right thing, HIV/AIDS is a totally preventable disease.

(Endnotes)

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