

**Syphilis Elimination Effort Literature Review  
Focused on Men Who Have Sex with Men and Their  
Attitudes and Perceptions of Syphilis**

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**Submitted January 31, 2002**

## INTRODUCTION

The purpose of this environmental scan was to learn about attitudes and behaviors of gay men and nonidentified-gay men who have sex with men (MSM) as they pertain to syphilis. This information can be applied to guide development of a communication strategy to address syphilis elimination activities among the MSM population. The specific topics that this environmental scan addressed were:

- Demographic and cultural characteristics of men who have syphilis
- Demographic and cultural characteristics associated with high-risk sexual behavior
- Attitudes and beliefs that coincide with high-risk sexual behavior
- Risk perception and risk management strategies employed by men who do not engage in safer sex, and the relationship of these perceptions and strategies to demographic and cultural characteristics
- Attitudes and beliefs that are barriers to screening
- Channel and message preferences by different segments of gay and nongay identified men who have sex with men
- Existing interventions with targeted populations, such as outreach and media messages

The intention was to review the most up-to-date information on the topic. Whenever possible, we looked at the literature on MSM and syphilis, but we also included literature on MSM and other STDs and HIV.

This environmental scan has a number of limitations. First, the majority of sources—especially those addressing prevalence of risk behavior, risk perception, and barriers to screening—focused on HIV. Since we excluded articles on needle sharing, the articles reporting data on risk behavior are pertinent to this inquiry, given that unprotected sexual activity puts one at risk of both HIV infection and syphilis. However, the information on attitudes toward risk of contracting HIV and barriers to HIV screening have been extrapolated to syphilis in view of both the levels of awareness of the respective diseases and the potential clinical outcomes.

Second, there is little basis to construct an audience profile for groups other than gay identified MSM. The centers of gay culture, according to Claritas and PRIZM databases, typically include the “Bohemian Mix,” “Young Literati,” and “Urban Achievers” clusters. (Descriptions of these clusters are found in Appendix C.) A survey of primarily gay men in Washington, DC, reported that more than 80 percent of respondents had either college or graduate degrees, and another 12 percent had at least some college (HHA, 2002). The literature provides little in terms of identifying demographic or cultural characteristics of nongay-identified MSM, making it difficult if not impossible to create a detailed profile of this group. As we note below, anecdotal evidence suggests that white married men may be patronizing bathhouses and other venues that offer opportunities for anonymous sex. This information about nongay-identified MSM is too limited, however, to construct a specific audience profile. Further research is needed on the demographics and lifestyles of nongay-identified MSM.

## Methodology

To develop concepts and messages for gay men and nongay-identified MSM, American Institutes for Research (AIR)/Prospect reviewed the most recent relevant literature and then developed and implemented the following methodology.

The entire Centers for Disease Control and Prevention (CDC) Divisions of HIV/AIDS Prevention (DHAP) Web site was reviewed, with specific attention paid to reports on best practice recommendations and relevant demonstration projects.

AIR/Prospect obtained articles from the MACRO database created for CDC. These articles were sorted and selected by both relevance and timeliness, and approximately 50 items were reviewed.

A standardized summary sheet was created (Appendix A) and was used to categorize each of the reviewed articles. This summary sheet recorded major topics, type of publication or source, methodology (qualitative or quantitative), various sample characteristics (sexual orientation or identification, race/ethnicity, socioeconomic status (SES), geographic location, etc.), and any relevant findings or recommendations. A summary sheet was completed for each of the reviewed articles.

AIR/Prospect reviewed background information sent from CDC and MACRO. This included focus group reports, environmental scans, and other reports.

In addition to the review of the already-collected literature, AIR/Prospect conducted a secondary search of recent literature to capture articles from medical and social science databases. This literature search was intended to fill in remaining gaps. Specifically, AIR/Prospect sought to find information to supplement what had already been reviewed, including research specific to communication messages and media targeting both gay men and nongay-identified MSM. The keywords and resulting Medical Subject Headings (MeSH) search terms used for the MEDLINE search were:

<b>Keywords</b>	<b>MeSH Terms</b>
Risk behavior	Risk-Taking
Health behavior	Health Behavior Sex Behavior
MSM	(NO MeSH term appear in MEDLINE)
Gay	Homosexuality, Male
Bisexual	Bisexuality
Communication methods	Communication

	Communication Media
HIV/AIDS	HIV Acquired Immunodeficiency Syndrome
Syphilis	Syphilis
Community-based prevention	Preventive Medicine Residence Characteristics (e.g...)
Sexual activity	Sex Sexual Partners Sexuality
Psychology	Psychology

At the same time, AIR/Prospect conducted phone interviews with STD program contacts in several states and localities that were selected by CDC program consultants. A questionnaire (see Appendix B) was developed to standardize information received from State and local contacts. Questions included information on locally produced messages on HIV or STDs or campaigns targeting either gay men or nongay-identified MSM, venues of distribution, existence of outreach activities encouraging testing or prevention, existence of any new “fads” or behaviors that could be increasing risk for gay men or nongay-identified MSM, levels of awareness about syphilis, issues of stigma, key influencers, key partners, and the existence of any evaluation of activities. Additionally, State and local contacts were asked to send any published or unpublished materials, reports, presentations, or evaluations that may be of interest.

## **FINDINGS**

### **Patterns of Epidemic and Associated Risk Factors**

According to the CDC, syphilis rates have decreased among most of the population except for men (CDC, 2000b). The increase among men is attributed to outbreaks among MSM in Chicago, Los Angeles, New York City, San Francisco, Seattle, and Miami. The reported epidemiological data do not provide clear guidelines for targeting the MSM population on the basis of demographic characteristics, such as age, race/ethnicity, socioeconomic status (SES), or sexual identity orientation.

Some reports provide clues to the patterns of the outbreaks. For example, Farley (2000) notes that “in California, about 25 percent of men with syphilis had sex in bathhouses or clubs during the time in which they were likely infected; in Seattle the number was 46 percent,” adding that CDC is investigating the role of bathhouses in several other cities. However, no empirical data exist to suggest whether individuals were infected in the bathhouses or other public sex venues. According to data from bathhouses in Washington,

DC, 28 percent of gay men surveyed met their sex partners in a bathhouse, and 28 percent report bathhouses as one of the places they engage in sex (HHA 2002). Internet chat rooms have been identified as indirect sources of syphilis outbreaks, as data suggest that men who meet other men on the Internet have a higher incidence of syphilis (Toomey and Rothenberg, 2000; Klausner et al., 2002). Data reported from Washington, DC, confirm the popularity of the Internet as a virtual meeting place for the gay community; 30 percent of men there reported meeting their partners over the Internet (HHA, 2002). The findings of these reports are consistent with findings by Farley et al. (2000) that transmission of syphilis has been occurring through established sexual networks that include a small core group of transmitters.

Epidemiological data also indicate an association between HIV-positive status and syphilis infection among MSM. In New York City, 30 percent of men infected with syphilis were HIV positive (CDC, 2002a). The 2000 CDC STD Surveillance Report (2002c) notes the rate of syphilis is six times higher in HIV-positive MSM than in HIV-negative MSM.

According to recent studies, age also can be considered as a possible factor insofar as it affects safer sex practices among MSM (Molitor et al., 1999; CDC, 1999b). According to these studies, younger MSM (<30 years old) are less likely to practice safer sex and more likely to engage in high-risk behaviors. A number of reasons for this phenomenon will be discussed below. However, specific data on syphilis in New York City (CDC, 2002a) and Seattle (CDC, 1999d), the median age of MSM who are infected with syphilis is 35. As noted by Somlai et al. (2001), patrons of bathhouse and sex clubs tend to be older and white. However, data from Chicago ([www.gettestedchicago.org](http://www.gettestedchicago.org)) suggest that the median ages of Hispanic and African-American MSM (ages 30 and 31, respectively) are younger than the median for white men (age 37).

Data on condom use (CDC, 1993) suggest that nongay-identified MSM are less likely than gay-identified MSM to use condoms and thus may be at greater risk to contract syphilis. Somlai et al. (2001) also note that many patrons of public sex venues who are not identified as gay, and often are married, were less likely to practice safer sex than the men identified as gay. However, no specific data suggest that syphilis rates are higher among nongay-identified MSM. Furthermore, although their findings cannot easily be generalized to the United States, in a recent Canadian study, Huber and Kleinplatz (2002) found that nongay-identified MSM are typically not found in public sex venues, such as bathhouses or parks.

When considering socioeconomic factors, the poverty rate has been associated with syphilis prevalence (Kilmarx and St. Louis, 1995), and issues such as access to care and the drug culture that involve survival sex have been widely noted as contributing factors (Farley et al., 2000; Huang et al., 2000). However, indications are that both gay and nongay-identified MSM who contract syphilis have higher SES than that of previously identified at-risk populations. For instance, reports on the syphilis outbreak in New York City (CDC, 2002a) note increased incidence of syphilis among whites who use private care physicians. This association suggests a certain degree of affluence among individuals who are infected with syphilis. These data are consistent with descriptions of patrons of public sex venues.

## **Awareness of, Knowledge of, and Attitudes Toward Syphilis Among MSM Populations**

In general, few data have been published on awareness of syphilis among MSM. One exception is a survey conducted during the Mr. Leather Convention in Chicago and published as an abstract at an STD Conference. This particular study reported a low level of awareness among participants of syphilis as a health threat.

Interviews conducted by AIR/Prospect staff with individuals who are implementing syphilis prevention programs suggest a somewhat different story. Typically, the respondents report a high degree of awareness of syphilis as a health threat among gay men who are in tune with the gay community, in which current and previous outreach efforts target gay men. On the other hand, respondents indicated that the level of awareness is low among nongay-identified MSM and especially among MSM of color. One notable exception is Washington, DC, where the key informant reported high awareness of syphilis among both gay men and nongay-identified MSM.

A survey of residents living in high-incident syphilis areas in Houston found that almost everyone surveyed had heard of syphilis (Baseman et al., 2001). The issue here may be general awareness of syphilis (i.e., “Yes, I have heard of the disease”) versus a perception that syphilis is a current health issue. For instance, during the formative research for the Syphilis Elimination Effort (SEE), most individuals working for community-based organizations knew what syphilis is but considered it a health concern of a previous era.

It is not clear to what extent gay and nongay-identified MSM know about methods of transmission, symptoms, and treatment of syphilis. The prevention efforts in San Francisco, Virginia, and Chicago all stress that syphilis is curable, and the effort in San Francisco informs about the symptoms. One may assume that safer-sex messages targeting HIV infection could be generalized to suggest prevention strategies for syphilis as well. Knowledge of syphilis has been related to overall educational attainment (Williams and Ekundayo, 2001). This relationship suggests that higher SES nongay-identified MSM and members of the gay community, who tend to be more educated than the general population, may be relatively more knowledgeable about syphilis.

Chatterjee, Ross, and Leonard (1999) reported finding, in predominantly low-income African-American communities in Houston, a relatively low knowledge of syphilis symptoms and the misperception that syphilis is incurable. However, respondents were able to identify condom use as a prevention strategy. Okwumabua et al. (2001) reported a low level of knowledge among members of a low-income African-American community in Memphis. Interestingly, Chatterjee, Ross, and Leonard also reported that a large percentage of individuals who sought treatment did so because of observed symptoms. A study in Baltimore (Williams and Ekundayo, 2001) reported a higher knowledge of syphilis among older individuals (40 and over), thus reinforcing the notion that syphilis may be considered a health problem affecting past generations.

Attitudes toward syphilis vary by communities. Based on our formative research, respondents in Los Angeles reported that the gay community considers syphilis a “dirty” disease, signifying patronage of male prostitutes, many of whom are from lower SES. In fact, Somlai et al. (2001) observed a distinct subculture of older white gay men who meet with younger African-American male prostitutes in public parks. In contrast, the African-American respondents reported that, due to the lack of association between syphilis and homosexuality (in contrast with HIV), syphilis has fewer stigmas in the African-American community and in fact could be considered a “war wound”—a badge of honor signifying one’s sexual prowess. On the other hand, Williams and Ekundayo (2001) noted that, in the African-American community, syphilis represents uncleanness, is associated with poor hygiene, and is seen as a “dirty” disease. Nothing was reported regarding attitudes toward syphilis among white middle class communities.

Among African-American communities, especially in the South, syphilis is associated with the Tuskegee experiment (Williams and Ekundayo, 2001). The result is the mistrust of the government and medical establishment reported by Balshem et al. (1992) and by Scientific Communication Group (SCG, 2000) focus groups. The implication of this association is discussed below.

Our environmental scan did not find specific data regarding awareness of syphilis among younger MSM, nongay-identified MSM, or HIV-positive men.

### **Attitudes Toward Safer Sex Practices**

The literature notes a decrease in safer sex practices among all segments of MSM populations and especially among younger gay men (Wolitski et al., 2001). At the center of the issue is the willingness of individuals engaged in high-risk sexual behavior to forego the use of male latex condoms, the use of which is widely believed to interfere with sexual gratification. As reported by Diaz and Ayala (1999), one gay Latino man expressed the sentiment as follows:

*Condoms have been always very uncomfortable to me, because when you wear, as they say, the glove, I don’t feel the warmth of the other person. You feel their coldness because it is plastic; you are not going to feel that little cozy warm feeling. And when they cum, you can’t feel it either. When I’m with condom, I can’t feel, oh but yes, they are very hygienic...*

In fact, when asked to rate possible characteristics of a hypothetical HIV-prevention product, men who engaged in anonymous sex were more likely to emphasize noninterference with sexual pleasure as the most important feature (Rader et al., 2001). Use of drugs and alcohol, associated with “free” or anonymous sex, provides escape from normative expectations such as safer sex practices (Williams et al., 2000). Drugs and alcohol are also used both to decrease inhibition (Molitor et al., 1999) and to enhance sexual experience (Ostrow, 2000). The popularity of Viagra among patrons of public sex venues, as reported by respondents to AIR/Prospect interviews, further supports this premise. The use of Viagra in the gay community has also been reported in the media

(Will, 2002) and has been implicated in an increase of unsafe sex practices and in the increase in the rate of STD infection (Kim et al., 2002).

A segment of the gay population that engages in barebacking consciously rejects the use of male latex condoms, signifying to some extent rejection of the mainstream gay culture of institutionalized safer sex. According to media coverage of the barebacking movement, a central belief is that “raw sex” is “real sex” (Elovich, 1999); some adherents emphasize the exchange of bodily fluids. As quoted by Scarce (1999):

*There's no better way to bond with a man than to give or receive sperm. A lot of bottoms take it into their bodies and keep it there as a way of remembering the sex. They want to feel it inside them and keep experiencing that closeness. It's a physical expression of intimacy.*

A number of factors that have been suggested to explain the decrease in the safer sex practices are associated with both the intentional rejection of as well as relapses in safer sex practices. Many sources mention “prevention burn out” (e.g., CDC, 2002a) resulting from long-term exposure to prevention messages and attempts to maintain safer sex practices. Few studies, however, explain the psychology of “prevention burn out” per se. One reason noted is that the reported belief in the effectiveness of the HIV antiviral therapies has decreased the perception of risk, thus counteracting health messages. For instance, Ostrow (2000) argues that central beliefs of barebackers are belief in the effectiveness of antiviral therapies as well as the insistence that there are no new drug-resistant strains of the HIV virus. These same attitudes were noted among individuals representing a broader gay community (SCG 2000). Siegel and Doner (1999) place the blame on public health practitioners who advocate the unyielding message of using condoms for every sexual encounter. Given the perceived impossibility of total compliance with this message, some persons simply give up or alternate periods of safe and unsafe sexual practice (Williams et al., 2000). Others practice what may be considered selective compliance. Thus, individuals in steady relationships are less likely to use condoms with primary partners (Vincke and Bolton, 1997). Ostrow (2000) notes fatalism about HIV infection as a more extreme manifestation of “prevention burn out.” That is, not being able to live up to high standards of safer sex, one simply becomes resigned to the belief that one is doomed to be infected and to infect others. In data from the focus groups conducted by SCG for the “Know Your Status” campaign, this fatalistic attitude was most pronounced among lower SES individuals who did not believe that antiviral therapies are available in their community.

Risk taking in general has also been noted as a characteristic of some segments of gay culture that leads to the disregard of safer sex practices. As noted by Siegel and Doner (1999), the attractiveness of unprotected sex is exactly that it is risky. Siegel and Doner attribute this phenomenon to psychosocial factors that are inherent in the identity of some gay men and predispose them to self-destructive behaviors. Ostrow (2000) identified loneliness, anger, and stress as the emotional components, along with risk taking and sensation seeking as affective moderators, that serve to psychologically dampen the effects of these underlying feelings. The extreme manifestation of this risk taking is the practice of



intentional passive anal intercourse with a known HIV-positive individual, as noted by Seal et al. (2000). However, this practice represents an extreme phenomenon.

As noted in the literature, other factors leading to a decrease in safer sex practices are either risk-reduction strategies or denial of risk by MSM groups. SCG focus groups, for instance, found that partner selection is one of the primary risk-reduction strategies. Others have noted a belief in the relative safety of unprotected oral sex in comparison to unprotected anal sex (Williams et al., 2000), leading to modification of sexual practices that individuals believe will minimize risk (Page-Shafer et al., 2000). For instance, findings suggest that HIV-negative men are more likely to engage in unprotected insertive anal sex, motivated by a belief that the practice does not put them at risk. HIV-positive men are more likely to engage in receptive anal sex and are less likely to ejaculate into a partner whose HIV status they do not know or who is HIV negative, thus trying to minimize the chance of passing the infection (Van de Ven et al., 2002).

Denial of risk has been noted among African Americans who believe themselves not to be at risk for HIV infection despite engaging in high-risk behaviors (CDC, 2002d). This denial of risk has also been reported in the gay population (Ostrow, 2000; Williams et al., 2000). One explanation (offered by Weinstein, 1989 as cited by Williams et al., 2000) suggests that some individuals culturally differentiate themselves from groups perceived to be at high risk for HIV infection and thus believe they are not at risk. The social stereotypes that perpetuate perception of minimized risk, in contrast to “other” high-risk groups, may explain how partner selection strategies are applied to essentially anonymous sexual encounters. By definition, stereotypes are cognitive heuristics (mental shortcuts) that facilitate quick decision-making, often based on superficial and overly generalized characteristics. As such, stereotypes may be used to make a quick decision regarding a potential anonymous sexual partner. For example, respondents in SCG focus groups noted that they have sex with only “healthy” partners. This statement suggests that they had devised some superficial means of assessing whether the potential sex partner is healthy without knowing his/her sexual history.

The discussions of the increase in unprotected sex among younger MSM note an important point regarding the psychological dynamic of why individuals may not practice safer sex. For instance, citing Rofes’ book *Reviving the Tribe*, Fleming, in *The Washington Blade*, suggests that younger gay men simply did not grow up in the “AIDS culture” and hence may not find the HIV-prevention message relevant. Writing for the *POZ* Web site, Richard Elovich notes:

*A large number of young gay and bisexual men live with their families, unconnected to a gay world except when they are having sex. Many others, though they live on their own, are more attached to a loose network of friends or bar buddies than to a structured gay community. Global conceptions of gay life and AIDS no longer reflect the realities most men are living.*

Molitor et al. (1999) noted that knowledge of health risks does not lead to safer sex practices among young MSM. Flowers et al. (1996) noted a weak relationship between

knowledge and safer sex behavior, as reported in a number of studies included in their quantitative review. Since knowledge, per se, does not lead to less-risky behavior, mediating factors are assumed to affect the relationship between knowledge and behavior. Molitor et al. (1999) suggested one such factor is a lack of communication skills among younger MSM to negotiate condom use with a partner. Similarly, on the basis of focus group research with young MSM, Seal et al. (2000) noted, as another contributing factor, the perceived social norm of promiscuity in the gay culture among young gay MSM.

The data also show that nongay-identified MSM are less likely than gay men to practice safer sex (CDC, 1993). One explanation why nongay-identified MSM are less likely to practice safer sex is similar to one offered by Rofes in regard to younger MSM: they are disengaged from the gay community that is likely to be the target for safer sex messages or they may find such messages irrelevant. In fact, the previously cited study notes that nongay-identified MSM who have a strong connection to the gay community are more likely to practice safer sex. Goldbaum et al. (1998) also noted that straight-identified MSM were least likely to report exposure to anti-STD messages in the previous 90 days and may avoid gay-focused material. Disengagement from the mainstream gay community, and hence the safer sex messages targeting that community, has also been offered as an explanation as to why Hispanic and African-American MSM (who often do not identify themselves as gay due to the stigma associated with homosexuality found in their communities) have higher incidents of high-risk sexual behavior (CDC, 2002d).

However, risky sexual behavior may be explained by other aspects than receptivity to safer sex messages or knowledge of risks. For instance, as reported earlier, it is possible that nongay-identified MSM may not have become aware of the syphilis outbreaks. It is doubtful, however, that they are unaware of HIV risks associated with unprotected sex. As noted previously, health information, per se, does not always lead to healthy behavior. One plausible alternative explanation is that, by being disengaged from the gay culture, nongay-identified MSM simply do not adopt safer sex norms of the mainstream gay culture. Another plausible explanation is that by not considering themselves “gay” and considering HIV to be a “gay disease,” these individuals psychologically minimize perception of their own risk by differentiating themselves from what they consider to be an “infected group.” As one nongay-identified young man was quoted by Seal et al. (2000), “Sex is sex,” but it is the expressions of affection toward another man that make one “gay.” Thus, the self-stereotype of themselves as “not gay” may also lead straight-identified MSM to ignore material targeting the gay community. A third explanation may be based on the type of sexual activity preferred by some segments of MSM. For instance, according to anecdotal reports, some segments of nongay-identified MSM (especially African Americans, Hispanics, and men of Middle Eastern descent) exclusively engage in either insertive anal intercourse or receive oral sex and would never submit to passive anal intercourse or provide oral sex. It is therefore possible that they, like some HIV-negative gay men, believe that these activities do not put them at risk.

HIV-positive men represent a distinct group in relation to male latex condom use and sexual practices. With advances in antiviral therapies, HIV-positive men are living healthier lives and, in many cases, their viral loads are almost undetectable. Despite some

psychological and physical consequences of HIV infection, sexuality remains an important part of their lives. One reason why HIV-positive men would not use male latex condoms with an HIV-positive partner is obvious: the main reason for safer sex—preventing HIV infection—no longer applies. As noted by Gold and Skinner (1994), HIV-positive men believe they have nothing to lose by not practicing safer sex.

On the other hand, research shows that HIV-positive men are willing to take steps not to intentionally infect HIV-negative partners or those whose status is not known. For example, Colfax et al. (2002) noted a decrease in unsafe sex practices with serodiscordant partners among individuals recently diagnosed with HIV infection. As noted above, HIV-positive men are more likely to engage in receptive anal sex (Van de Ven et al., 2002), possibly to minimize the potential of infecting others. Cicaronne et al. (2000) reported that, although 16 percent of HIV-positive men surveyed engaged in unprotected anal sex, only 3.2 percent practiced insertive anal sex with ejaculation. Colfax et al. (2001) reported higher incidents of unprotected anal sex with serodiscordant partners among HIV-positive men who attend “circuit parties” outside of their immediate community, although the study did not specify whether the HIV-positive men were more likely to engage in receptive or insertive anal sex.

### **Attitudes Toward Testing**

Unlike their attitudes toward practicing safer sex, individuals who are at risk of HIV are more likely to seek testing than individuals who are not at risk (Anderson et al., 1999). However, the CDC reports that many young gay and bisexual men (CDC, 1999b), as well as a large proportion of African-American and Hispanic men, are not aware of their HIV status (CDC, 2002d). Data from Washington, DC (HHA, 2002) suggest that MSM are even less likely to be aware of their syphilis status; only 7 percent of men surveyed reported a recent syphilis screening.

One of the recognized barriers to testing for HIV is simply fear of the outcome. In other words, some individuals simply do not want to know. As reported by the SCG (2000) this attitude was most prevalent among lower income African Americans who believe that new drug therapies are not available in their community. This fear of knowing is associated with the fatalism about HIV infection noted earlier in relation to high-risk sexual behavior. In contrast, a British study (Sherr et al., 1999) found that many gay men in London sought testing because they believed it is better to treat HIV early. As noted below, there are indications that the gay community in the United States shares this sentiment. These findings have a direct implication for syphilis, since syphilis is effectively treatable, especially when it is discovered early. The extent to which fatalism associated with HIV generalizes to syphilis is not known.

Another salient attitude widely reported for both HIV (SCG, 2000) and syphilis (Baseman et al., 2001) can be summarized as “once is enough.” Individuals who have been tested previously are less likely to seek testing again, despite engaging in high-risk behaviors. It is possible that the negative results of a single test confirm the self-perception of not being at risk for an STD.

Baseman et al. (2001) reported perceived lack of risk is another factor affecting refusal for syphilis screening. Here the psychological dynamics seem identical to those described previously that lead individuals to engage in high-risk behaviors. Factors associated with the testing procedure, such as fear of needles and not wanting blood drawn, have also been noted as a psychological barrier for syphilis testing (Baseman et al., 2001) and HIV testing (CDC, 2002d).

Confidentiality of testing was another potential barrier noted in the SCG report (2000). Respondents expressed reservations concerning whether any testing can be truly confidential. Partner notification is a similar issue.

On the basis of our interviews, communication with health care providers is another potential barrier to syphilis testing that affects nongay-identified MSM. Urban gay men, who tend to go to gay-friendly health care providers, receive messages about prevention and treatment. Nongay-identified MSM, in contrast, are not likely to go to their family practitioner (if they have one) and ask about syphilis. Furthermore, the health care provider is not likely to bring it up. Malebranche et al. (2001) noted issues pertaining to communication between African-American MSM and their health care providers. For instance, some men said that they hide their sexual orientation or sexual practices for fear of being judged or labeled.

### **Sources of Health Information**

Among men in their early twenties, mass media are the most common source of information about STDs (Bradner et al., 2000). The SCG report (2000) also notes media as a source of health information. Both sources note friends and family as other important sources of information. Goldbaum et al. (1998) found no difference in the mass media reach for AIDS information between gay-identified and nongay-identified MSM. However, the same study notes that, for nongay-identified MSM, friends and family are a less frequent source of STD information. For example, news stories commonly circulate among the population. Therefore, individuals who may not have seen or read a story in the media might hear about it from their friends and family. It is doubtful, however, that stories pertaining to health risks of the gay community would circulate among the social networks of nongay-identified MSM.

On the basis of our interviews, physicians appear to be an important source of health information about STDs, but only for the gay community and only when the physicians are gay friendly. We suspect that this may be the case especially for HIV-positive men who are in frequent contact with the physicians who manage their treatment. As noted above, nongay-identified MSM are reluctant to talk to their physicians about STDs, and their physicians do not generally discuss the issue. Goldbaum et al. (1998) noted that, in comparison to gay men, straight-identified MSM were less likely to receive AIDS information from their physicians.

The SCG (2000) report also suggests that the Internet may be a new and important source of health information, but only for the more affluent and technologically savvy, e.g., the “New Bohemian Mix” that includes a number of gay men (See Appendix C). One may surmise that the Internet is also a major source of information for the more affluent, nongay-identified MSM who are in this cluster.

There are some indications that government agencies, especially on the Federal level, may be considered a suspect source in the African-American community. In regard to HIV, SCG (2000) reported two prevalent myths: (1) the Government is withholding treatment from the African-American community, and (2) HIV was created by the Government and released intentionally into the black community. Distrust of Government in relationship to syphilis stems from the revelations about the Tuskegee experiment (Williams and Ekundayo, 2001).

According to data from a survey of MSM conducted in the District of Columbia (HHA 2002), more than 50 percent of gay men expressed preference for bars and clubs in addition to the Internet as places where they would like to receive information on HIV. More than one-third of the respondents mentioned bathhouses, gyms, and adult bookstores as potential information resources.

### **Message Content**

It appears that the message content for HIV and STD prevention has shifted from promoting safer sex to encouraging testing and screening. An SCG report (2000) on formative research for the “Know Your Status” campaign provides specific data on how different messages (encouraging HIV screening) tested among different segments of targeted populations. The tested messages addressed issues of perceived risk, HIV burnout, and fear of finding out positive results. In general, the messages did not test well among participants except those representing the “Bohemian Mix” cluster (See Appendix C), many of whom were gay men. Messages addressing perceived risk scored low on personal relevance among all clusters, suggesting that self-deception is strong concerning one’s own personal risk for HIV. The message that addressed the fear of learning results scored well with Hispanic and inner city clusters. Members of lower SES clusters were more skeptical of messages suggesting that early detection of HIV would facilitate treatment, but this message was better received by gay men. As noted above, gay men in London (Sherr et al., 1999) said that a belief that early detection would facilitate treatment was a motivating factor to get tested.

San Francisco’s “HIV Stops With Me” campaign stressed personal and community responsibility, using spokespersons recruited from San Francisco’s gay community. According to the findings provided by the advertising/social marketing agency that created the campaign (Better World Advertising, 2001), most respondents interpreted the campaign as encouraging personal responsibility. Although targeted at the gay and transgender community, the campaign reportedly also had an impact on bisexual and heterosexual respondents.

To what extent these findings apply to syphilis is an open question. It is doubtful that messages emphasizing the risk of syphilis would penetrate the psychological defenses erected by the target audiences who deny their own risk of HIV and other STDs. On the other hand, the examples of syphilis-prevention campaigns we examined all stress that syphilis is curable, and some suggest long-term consequences of not being treated—similar to the “*Today, if you have HIV, there is something you can do about it*” platform tested by SCG. As noted above, this message was well received by higher SES groups, but lower SES groups were more skeptical, perhaps due to their mistrust of the medical establishment. It is not known whether distrust of the medical establishment translates into skepticism about an ability to cure syphilis.

It is also not clear whether the messages of either community or personal responsibility would resonate with men who engage in unprotected sex in public venues. As noted by Ostrow (2000), the “barebacking” or “raw” subculture is in fact based on the rejection of safer sex norms and appears to strive to bring back the “free love” sensibilities of gay culture before AIDS. Chances are that these safer sex messages also would not appeal to nongay-identified MSM.

The syphilis prevention messages targeting the gay community typically use homoerotic imagery or make specific references to the gay community.

- In Virginia, for example, materials handed out to MSM in high-risk sex venues feature images of muscular men with a tag line “Do you like sex?” The text stresses the relationship between syphilis and HIV and informs that syphilis is curable.
- The San Francisco “Healthy Penis 2002” campaign makes specific references to Castro Street and portrays evil, anthropomorphized syphilis sores attacking the gay community in bathhouses.
- A campaign in Chicago features an image of a group of “typical” gay men and stresses community responsibility in its message.
- Clearly, these messages may not be relevant to the nongay-identified MSM who in general do not identify with the gay community.

Some lessons can be learned from two successful campaigns. London’s “Gimme 5 Minutes” campaign targeting gay and bisexual men (McOwan et al., 2002) achieved a substantial increase in the number of men in its targeted demographic groups who sought HIV tests. The campaign had two important characteristics: it used peer images of the targeted populations (African and South European men), and it provided a specific location for screening. The two components of the campaign addressed the following two barriers to testing: (1) it personified risk, making the issue relevant to targeted groups, and (2) it provided a clear behavioral directive by listing a specific clinic where screening is done.

The CDC’s AIDS Demonstration Project (1999c), that used outreach workers and volunteers to distribute peer role model stories, safer sex kits, and bleach for syringes, has led to an increase in HIV-prevention practices in targeted communities. The theoretical basis of the campaign used the stages of change model (Prochaska and DiClemente, 1983). The peer model stories depicted real individuals in various stages of contemplating or

implementing HIV-prevention behaviors. The stories were designed to encourage individuals to move to the next stage in the continuum leading to finally maintaining HIV-prevention behaviors. The success of the campaign can be attributed to several factors. First, by using stories about people representing targeted populations, like the “Gimme 5 minutes” campaign, this effort personalized the problem and made it relevant to the audience. Second, the message of the story did not ask the audience to make a big leap from risky behavior to safer behavior but encouraged incremental changes. Third, the stories demonstrated how the incremental change could be made, thus making the message more palatable and manageable for the target population.

This approach may hold promise for the issue of screening as well. Individuals who have not been tested for syphilis are at a different stage than those who have been. In the former case, the individuals who have not been tested for syphilis are precontemplators, or perhaps contemplators if they are aware of syphilis as a health issue. The communication challenge is to move to action. But, as noted earlier, a number of individuals may have been screened already, and in their minds that one screening sufficed. With these individuals, the goal would be to convince them to maintain their behavior and be screened on a regular basis.

### **Existing Interventions**

On the basis of AIR/Prospect interviews, published literature (CDC, 1999d), and the CDC, outreach interventions for syphilis with gay and MSM populations are conducted in venues where high-risk behavior is likely to occur, e.g., bathhouses, bars, and public cruising areas such as rest areas. Reported intervention activities include:

- Adapting posters and materials for local use (including local screening information)
- Using a mobile screening and education van at Pride events and rest areas
- Conducting screening and education at bathhouses
- Adapting materials for African-American gay men
- Working with black and Latino health care providers to increase education and screening of MSM
- Creating posters, flyers, and cards used at rest areas
- Combining mobile van activities, such as blood pressure and other "less loaded" types of screenings, to encourage participation
- Posting messages about screenings on Internet chat sites

In some areas, these outreach activities are supported by media campaigns. The emphasis of the outreach intervention is predominantly on screening, although information about safer sex practices is also included.

Other interventions reviewed by Ostrow (2000) and those suggested by Molitor et al. (1999) and Seal et al. (2000) emphasize interpersonal communication skills to negotiate condom use with a partner. The methodology of implementing these interventions is beyond the scope of a social marketing approach, however, because more personalized counseling types of interventions are required.

## **CONCLUSIONS AND RECOMMENDATIONS**

### **Venue Implications**

Increases in syphilis rates among MSM appear to be concentrated among individuals who engage in unprotected anonymous sex in public venues or use the Internet to connect with anonymous partners. Although some persons may represent a distinct subculture in the gay community who have intentionally forsaken use of male latex condoms, the trend reflects the overall decrease in safer sex practices among MSM. High-risk behavior as a precursor to syphilis infection occurs despite the well-known risks for HIV infection and frequent safer sex messages. As noted above, knowledge of risk does not necessarily translate into safer sex behavior. Fatalism, perceived social norms, beliefs in efficacy of antiviral therapies, denial of personal risk, and risk management based on incorrect information and/or using potentially ineffective strategies mediate the relationship between knowledge and behavior. The motivation for adopting and keeping these attitudes often involves a belief that the use of male latex condoms interferes with intimacy and with the quality of sexual experience. It should be noted that some of the salient beliefs held by MSM concerning the alleged safety of insertive anal sex, of not exchanging body fluids, and of oral sex in regards to HIV transmission clearly do not apply to syphilis.

For gay men, bathhouses and other venues may provide a context in which they may lapse from safer sex practices or have an opportunity to engage in high-risk sexual activity. The association of syphilis outbreaks with specific venues suggests that an intervention could be effectively conducted at the locations where high-risk sexual activity occurs. This is the case with most of the current approaches that we reviewed.

Indications are that in the gay community there is high awareness of syphilis as a current health risk, but awareness is lower among nongay-identified MSM. Even if syphilis is not perceived as an immediate health risk, most communities have knowledge of the disease.

### **Message Implications**

The communication challenge now is how to address the issue of the syphilis outbreaks among MSM in order to achieve the goal of eliminating syphilis. On the basis of our findings, we recommend that messages emphasizing syphilis screening would be more appropriate than those emphasizing prevention. The population at risk for syphilis has been exposed to safer sex messages to prevent HIV, a terminal disease without a known cure that requires a burdensome medical regimen to control the infection. Nevertheless, these men still engage in behaviors that put them at risk of contracting HIV. It is doubtful, therefore, that prevention of syphilis would be a sufficient motivation for them to change their behavior. Furthermore, male latex condom use is less effective in preventing syphilis than in preventing HIV infection. Thus, safer sex messages emphasizing use of male latex condoms in regards to syphilis would have to be “watered down” in respect to the claims of their effectiveness, and consequently would not appear powerful or convincing. In fact, they may inoculate targeted audiences against the necessity of using male latex condoms, leading to further rejection of safer sex practices. In other words, any hint of



ineffectiveness would justify for these individuals foregoing male latex condom use altogether.

The content of the messages should address the psychological and social barriers to screening have been addressed above. The barriers that were reported specifically in regard to syphilis screening or that appear to be most pertinent are:

- Belief of not being at risk either because of social differentiation, partner selection, or sexual practice
- Belief that previous screening “resolved the issue”
- Confidentiality of testing
- Fear of screening procedure (e.g., fear of drawing blood, needles)

It is not clear whether the fatalism associated with not wanting to know one’s HIV status generalizes to syphilis. This attitude may, however, be mediated by knowledge that syphilis is curable by antibiotics.

We may assume that the target audiences are aware that they are at risk; however, this awareness may be mediated by the same risk-reduction and risk-denial strategies we see with HIV. As a result, the members of the target audiences may not perceive themselves at risk personally and, therefore, may raise objections to screening. It follows that the messages should either address the factors that affect self-perception of risk or personalize the risk. For instance, information may be disseminated that both unprotected insertive and receptive anal sex put one at risk equally, regardless of whether semen is exchanged. Furthermore, considering that syphilis is prevalent in venues that have been identified, association with those venues could make personal risk salient (e.g., “If you are here, you are at risk.”). As previously noted, personalization of risk, by involving spokespeople from an affected community, has been demonstrated to be an effective strategy. We also suggest that communication strategies reinforce “regular screening” to counter tendencies to get screened once and then to forget it.

The content of messages should consider that the primary goal of high-risk behavior is to achieve a certain quality of sexual gratification or intimacy that many believe is impossible when using a male latex condom. The reasons for seeking screening and treatment could emphasize the consequences of not doing so that do interfere with men’s sexuality.

Given the recommended emphasis on screening, the possible prevention messages should be considered secondary. On the basis of this review, we recommend that the secondary prevention messages acknowledge possible lapses in safer sex practices.

### **Segmentation Implications**

The epidemiological data do not provide clear guidelines for segmentation except that HIV-positive men are clearly at greater risk. Essentially, all we know is that white MSM in public venues are at higher risk of contracting syphilis. However, reported trends toward lower safer-sex practices among younger MSM, African-American MSM, and Hispanic

MSM, as well as those who do not identify themselves as gay suggest that all these populations may also be at risk.

The key difference between gay men and nongay-identified MSM may be strategies used for risk management. In fact, for nongay-identified MSM, differentiation from gay culture may be one strategy to deceive themselves about the risks of unprotected sex. The same psychological maneuver may explain why nongay-identified MSM may consider as irrelevant to themselves the messages that specifically target gay men. Evidence exists, however, that campaigns targeting the gay community may also resonate with heterosexual and bisexual men. Because the preferred channel for disseminating material is outreach in public sex venues, one may wonder if it is feasible to have separate materials for gay and nongay-identified MSM. Nongay-identified MSM would also likely encounter information about syphilis in the context of their own communities. For these reasons, our final recommendation is not to segment by self-identified sexual identity.

On the other hand, we recommend that at least concept testing of materials be conducted, segmented by HIV status. A number of reasons underlie this recommendation.

- First, HIV-positive men may be more concerned with the impact of syphilis infection on their health and on their immune systems.
- Second, as suggested by reports of risk-management sexual behaviors by HIV-positive men, concerns about spreading the infection may resonate among them more strongly than among HIV-negative men whose main concern is not to be infected.
- Third, the discontinuation of male latex condom use by HIV-positive men with partners of the same serostatus is self-justified by already knowing their infection status. Introduction of syphilis into the equation contradicts that justification and lends uncertainty regarding one's syphilis status.
- Finally, HIV-positive men are assumed to have more frequent contact with their physicians. This contact suggests a possible channel to effectively disseminate information and to encourage screening, targeting HIV-positive men. This channel may not be as effective, however, for HIV-negative men.

The literature also suggests several reasons to consider race and ethnicity as possible population segmentation variables. First, we cannot dismiss possible cultural differences that may affect receptivity to messages. If we limit our target audience to gay-identified men, we cannot assume that one's identity as a gay man necessarily supersedes identification with one's own ethnic and racial group. For instance, syphilis disproportionately affects African-American communities. It is therefore likely that the gay-identified African-American men have greater awareness of syphilis as a health care issue and/or have the similar beliefs about syphilis as does the African-American community at large. These factors suggest that African-American gay men could respond differently than middle class whites to screening or prevention messages. Second, as noted above, African-American gay men express specific distrust of the medical establishment. Thus, they may have more reservations about screening and may be less likely to seek information from their health care providers. Third, studies have shown that risk behavior is more prevalent among African-American and Hispanic MSM(s). Part of the explanation

may be that some African-American and Hispanic MSM(s) do not identify themselves as gay. Consequently, they either do not consider themselves at risk and/or are not exposed to prevention messages targeting the gay community. However, it is not clear to what extent those findings apply to gay-identified African-American and Hispanic men. Therefore, it would be prudent to postulate that differences in behavior and risk-management strategies among these groups, in comparison to Caucasian gay men, may affect receptivity to the messages.

## ***APPENDIXES***

*Appendix A: Literature Review Guide*

Title  
 Authors  
 URL (if applicable)  
 Major Topic

<input type="checkbox"/> Syphilis	<input type="checkbox"/> HIV	<input type="checkbox"/> Other STD
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Type of Publication/Source

<input type="checkbox"/> Report <input type="checkbox"/> Journal Article <input type="checkbox"/> Conference Presentation <input type="checkbox"/> Website	<input type="checkbox"/> White paper <input type="checkbox"/> Manual <input type="checkbox"/> Secondary Data <input type="checkbox"/> Other
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Methodology

Qualitative	Quantitative
<input type="checkbox"/> Focus groups <input type="checkbox"/> Interviews <input type="checkbox"/> Ethnographic <input type="checkbox"/> Lit Review/Synthesis <input type="checkbox"/> Historical analysis	<input type="checkbox"/> Experiment <input type="checkbox"/> Quasi Experiment <input type="checkbox"/> Correlational <input type="checkbox"/> Secondary data analyses <input type="checkbox"/> Meta-analysis

Sample Characteristics

Sexual Identification	Race/Ethnicity	SES	Age	Geographic	Regional
<input type="checkbox"/> MSM * <input type="checkbox"/> Gay <input type="checkbox"/> Non-Gay	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Other	<input type="checkbox"/> Middle Class <input type="checkbox"/> Working Poor <input type="checkbox"/> Poor		<input type="checkbox"/> urban <input type="checkbox"/> rural	

\*sexual preference differentiation not reported

Findings/Recommendations (note important differences between groups noted if applicable)

- Awareness/perceived prevalence
- Knowledge of symptoms
- Knowledge of transmission
- Knowledge of treatment/perceived efficacy
- Social perceptions of people with disease
- Perceived Personal Risk
- Reported Risk Reduction Strategies
- Salient beliefs about prevention practices
- Attitudes toward testing
- Barriers to testing
- Media habits
- Preferred/trusted sources of health information
- Preferred/effective messages
- Examples of outreach activities
- Dissemination activities

*Appendix B: Interview Guide with Key Informants*

Hello my name is \_\_\_\_\_ from the American Institutes for Research, Prospect Center. As you may know, we are conducting an extensive environmental scan on knowledge and attitudes among men who have sex with men (or MSM) toward STDs, as well as on approaches to prevention AND TESTING for the Centers for Disease Control and Prevention. The information from this environmental scan will be used to design communication strategies for CDC's Syphilis Elimination Effort, which is targeting MSM.

I would like to ask you a few questions about local prevention AND TESTING efforts targeting MSM in programs you are familiar with. Please note that we interested in both programs that target the gay community as well as those targeting men who do not identify themselves as gay.

Would now be a good time? (If Yes, then proceed.)  
If NO: When would be a good time to call you back?

**Probe for documentation for all questions**

1. First, we are interested in any locally produced messages targeting the gay community that encourage testing or prevention (e.g., condom use). These messages could be about HIV/AIDS or any other STD.

Probe

for content (what do those messages say)  
target audience (e.g., age, race/ethnicity, etc.)  
venues of distribution (media, bathhouses, where do messages get placed)  
background research and access to those findings  
audience reaction (formal or informal) and possible assessments of audience reactions

2. Are you aware of any messages that encourage testing or prevention specifically targeting MSM who don't identify themselves as gay?

Probe

for content (what do those messages say)  
target audience (e.g., age, race/ethnicity, etc.)  
venues of distribution (media, bathhouses, where do messages get placed)  
background research and access to those findings  
audience reaction (formal or informal) and possible assessments of audience reactions

3. Are there other outreach activities you know of encouraging testing or prevention in your community that target the gay community?

Probe for

- a. Types of outreach
- b. Target audiences
- c. Venues for outreach
- d. Assessment of effectiveness
- e. Barriers to effectiveness

4. Are there other outreach activities you know of encouraging testing or prevention in your community that target MSM who do not identify themselves as gay?

Probe for

- a. Types of outreach
- b. Target audiences
- c. Venues of outreach
- d. Assessment of effectiveness
- e. Barriers to effectiveness

5. Are you aware of any new fads/behaviors that put the gay community or MSM at risk of syphilis or STDs (*note not necessarily exclusive to MSM community*)?

Probe

Drug behaviors

Sex behaviors

Distinction between gay and nongay

Package deals (e.g., Happy Meals)

Emergence of new attitudes/beliefs (INCLUDING COCKTAIL SURVIVAL MENTALITY?)

Sources of misinformation

SOURCES OF INFORMATION (i.e., INTERNET, LOCAL/NATIONAL EVENTS)

6. In general what would you say is the level of awareness of syphilis among the gay community and/or MSM individuals?

Probe:

Distinction between gay and nongay MSM

Sources of information about syphilis in the community

Reasons for the level of awareness (barriers and facilitators)

7. (If not specifically mentioned previously) Are there issues of stigma about syphilis or MSM that you think would have an impact on the effectiveness of any media or outreach campaign?
  
8. Who would you say are key influencers in gay and MSM communities (e.g., spokespersons, who do they get their health information from)?

Probe

Distinction between gay and nongay-identified MSM

9. Who would you say are some key partners in prevention activities?

Probe who are members of coalitions you work with

Probe for HIV/AIDS organization/perceived benefit of participation

Ending: Thank you very much for your time. Again, if you have published or unpublished

- Descriptions of programs (such as outreach, media campaigns, testing initiatives) targeting MSM
- Locally produced prevention materials for MSM populations
- Research reports, including focus group findings, epidemiological studies, survey findings, and evaluations of prevention program
- Presentations made at local or national conferences by local researchers or practitioners

We would like you to share them with us.

11/4/2002



Appendix C: You Are Where You Live

**27 Urban Achievers**

Mid-Level, White-Collar Urban Couples

Age group: 25-44, 65+

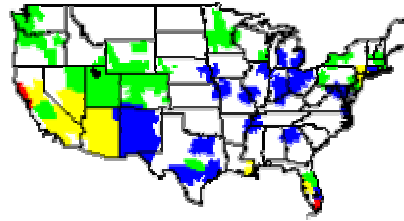
Professional/White-Collar

Household income: 40,000

1.59% of U.S. households belong to this PRIZM Cluster.

**This PRIZM Cluster is most likely to:**

- Attend pop/rock concerts
- Own an electronic organizer
- Use a debit card
- Watch ABC News Nightline
- Read *Gourmet*



**This PRIZM Cluster lives in neighborhoods like:**

- San Francisco, CA
- East Portland, OR
- Minnehaha, MN



**6 Urban Gold Coast**

Elite Urban Singles

Age group: 45-64

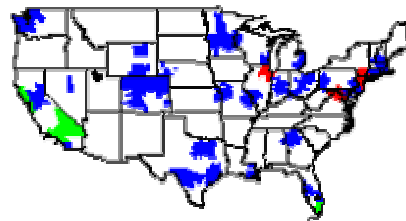
Professional

Household income: 73,500

0.57% of U.S. households belong to this PRIZM Cluster.

**This PRIZM Cluster is most likely to:**

- Attend the theater
- Use olive oil
- Bank online
- Watch Mystery
- Read *Self*



**This PRIZM Cluster lives in neighborhoods like:**

- Marina Del Rey, CA

## 10 Bohemian Mix

Bohemian Singles & Couples

Age group: 25-44

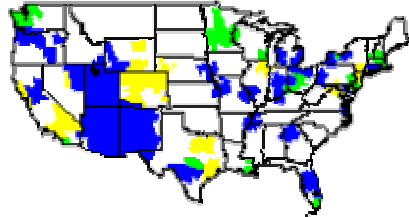
Professional

Household income: 38,500

1.47% of U.S. households belong to this PRIZM Cluster.

### This PRIZM Cluster is most likely to:

- Use call answering
- Shop at The Gap
- Have a rollover IRA
- Watch Face The Nation
- Read *Elle*



### This PRIZM Cluster lives in neighborhoods like:

- West Hollywood, CA
- Dupont Circle, DC
- Greenwich Village, NY



## 8 Young Literati

Upscale Urban Singles & Couples

Age group: 25-44

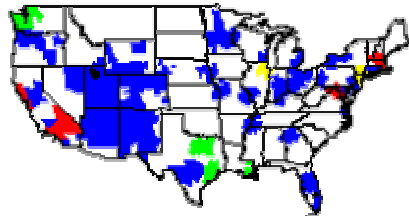
Professional

Household income: 63,400

0.92% of U.S. households belong to this PRIZM Cluster.

### This PRIZM Cluster is most likely to

- Plan for large purchases
- Take vitamins
- Use a discount broker
- Watch Bravo
- Read *GQ*



### This PRIZM Cluster lives in neighborhoods like:

- Hermosa Beach, CA
- Diamond Heights, CA
- Edgewater, NJ



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