

AFAO HIV Educators Conference Plenary Address

The Grand Ballroom, Manly Pacific Novotel Hotel,
Sydney, Australia, May 25th 2010

What's the point of HIV Prevention?

Ford Hickson, Sigma Research, UK

Introduction

Good afternoon. Firstly, I'd like to acknowledge the Aboriginal Custodians, past and present, of the land where we meet today, The Cannalgal Clan of the Garigal Nation. I'd also like to thank: AFAO for inviting me to address you and for making it possible that I do so; Colin Batrouney for his initial approach; and to Ben Wilcock for his organisation of my visit.

I'm very pleased to be here today, not least because Australia's HIV response, both in community health promotion programmes and in epidemiological and social research, has long been an inspiration to those of us working in the UK. Australia's contribution to our knowledge and understanding of HIV epidemics far outstrips the size of her population.

I'm hoping to take this opportunity to make a contribution to current debates about stigma and HIV prevention, by asking the question *What's the point of HIV prevention?* And in particular to look at the stigma we attach to sexual HIV risk.

CHAPS and Making it Count

The framework arises from England's CHAPS Partnership and I'm pleased to acknowledge my health promotion partners in England whose approaches I'm reflecting. It is their work that makes my work possible.

I'm going to draw on the fourth edition of *Making It Count*, the collaborative planning framework of a number of HIV education organisations serving men in England who have sex with men. Making It Count 4 is currently out for public consultation.

Tackle assault

Like fighting aids and sick jokes, tackling stigma is a metaphor for an approach. One meaning of tackling could be the thing that rugby players do. However, rather than being something we can knock out, stigma is in the very fabric of our social being. It is one of the ways in which we construct and maintain social hierarchies. We can no more bring down stigma like a footballer than we can cure a joke or punch a disease syndrome.

Tackle lift

Another, more subtle metaphor for tackling stigma, one that might elicit less combatative responses, is to tackle something so as to share its load and therefore make it easier to lift. Risk is very heavily stigmatised. It has a real bad image problem, a toxic brand. Current debates makes no allowance for good risks.

Us and them

The narrative logic of HIV demands that the epidemic usually be seen as someone else's responsibility, if not always someone else's problem. New infections are always someone else's fault. This is not only the story told by the heterosexual majority about the homosexual minority, but also the story told by the good gays about the bad gays.

The picture of population level risk this story paints looks something like this, which uses imaginary data. On the left are the majority of men who are sexually safe. On the right, the risk takers. HIV infections arise because of the intransigent behaviour of a small sub group in the population.

It is this understanding of risk distribution that keeps alive the character of the bug-chaser and which, in another version, is able to make the epidemic the responsibility of people with HIV, with those of us with HIV on the right and those of us without it on the left. In this version of the epidemic, the point of HIV prevention is to find and fix the dysfunctional, to make *them* like *us* or to disable them as a threat.

Side by side

If we take only anal intercourse without a condom in the last year as the mark of risk taking, we see that the group on the right is actually much bigger than this story paints. This is the picture in the UK in 1998, when about a third of men had UAI in the last 12 months. I've also closed the gap, which is nothing but a narrative device.

Ten years later and approaching half the men in the UK had UAI in the preceding year. It was recognised early on by men having sex, and somewhat later by those trying to intervene on men having sex, that not all occasions of anal intercourse are the same. Here we're looking at 12 month blocks of gay sex life.

In an important paper by Jin and colleagues published last year with data from the Sydney HIM study, 6 month blocks of gay sex life were allocated to four categories: no AI or AI only with a condom that never failed, on the left in this graph; UAI or condom failure only with men thought to be HIV negative; with men whose status was unknown but not with men they thought positive; and on the right, UAI or condom failure with men known to be HIV positive.

They also measure HIV-incidence within these periods of gay sex life.

While time spent on the far right does have a higher HIV incidence than time spent elsewhere, because a minority of time was spent there it contributed only 28% of the new infections; 28% arose in men having unknown UAI; 30% among men having UAI with men they thought were negative; and 15% among those having no UAI or condom failure.

It is not the case that time spent on the left, having sex with men but avoiding UAI and condom failure, contributes nothing to HIV incidence.

The HIV incidence measured in this group was 0.3%. The researchers caution that this may be

because of mis-allocation of sero-conversions to time periods. Whether this is the case or not, we do recognise that HIV can be acquired orally.

And men who never have anal intercourse, or who always use condoms, or who only have UAI with men they know have the same status as themselves, including positive men, can contribute to incidence by passing on other STIs, perhaps even if they themselves do not become infected, for example, if we are multi-fisting or multi-dipping.

And this graph is simplification a simplification of the risk profile. There is no risk-cliff between the groups. □ The second group could be split into periods of negotiated safety and periods of other 'thought negative partner UAI'. □ The no UAI group could be split into periods of no UAI and periods of AI always with condoms that never failed.

This figure includes only men without HIV and only one harm to themselves. So, for example, the passing of oral syphilis to an HIV positive partner while they were fellating him off, is not reflected here.

The shape of the curve is not only a function of the length of time we choose, but also of what we include as risk. All sex carries risk, either for ourselves, or our partners, or our partners' partners.

□ A comprehensive risk index that considers all contributions to HIV risk in a population might look something like this - a normal curve. The profile is smooth - there are no gaps or cliffs. If we're having sex we're in the profile. In this version of the epidemic the point of HIV prevention is to shift the entire profile to the left. What might the elements of such an index be?

□ **HIV-ometer**

We can think about an HIV incidence-ometer, that points to the current HIV incidence among men who have sex with men. A reasonable estimate of current HIV incidence in the population of all men in the UK who have sex with men is □ 0.5%.

HIV incidence is not simply the outcome of non-condom use. It is held in place by a large number of forces towards and away from infections. In the first line of these forces are the decisions men are making across a range of choices.

I'd like to briefly consider the nine choices currently proposed in *Making It Count* as those which are determining HIV incidence in the UK. Each of the choices presents two decisions that either contribute to or detract from HIV risk.

What I want to illustrate is that none of us wholly advocates 100% precautions all the time. If we think we are doing this, we are probably fooling ourselves about their risk and our safety.

□ **No test or test?**

The first precautionary choice is available to all of us all the time, except perhaps when we are having sex. It is whether or not we choose to test and if necessary treat for Sexually Transmitted Infections,

including HIV, before our next sex partner.

Perhaps the minimum contribution we can make to sexual risk while still having new sexual partners is to have two sexual partners on the trot without testing for STIs in-between them. Even if we engage in non-penetrative sex with both, there is still the possibility of transferring an STI from one to the other. If we engage in penetrative sex that probability increases, and if we do not use a condom it increases again. But even non-penetrative sex with multiple partners is not risk free: the probability we have still avoided an STI and are not now passing it on gets smaller with each new partner. It's getting smaller faster if we are having anal intercourse and faster again if we're not using condoms.

For everyone who acquires an STI, someone passes it on. The stigma of risk ensures that policy is framed in terms of protecting us from STIs rather than thinking about ourselves as the vehicles of infection for others. Unless of course we have HIV, in which case that is sometimes *all* we are seen as.

Having a sexual partner without an STI screen since the last partner is something almost all gay men have done, and almost all gay men will do.

One of the benefits of undetectable viral load might be being able to have unprotected intercourse with little concern for onward infection. However, this is also the activity most likely to result in an STI which can cause viral rebound. Which means our uninfected state, if that is what it is, is only as good as the number of men we've had UAI with since our last STI test.

The Swiss Statement on HIV infectivity was concerned only with vaginal intercourse in couples with mixed HIV status, where the positive partner has undetectable viral load, is adherent to meds and is free of other STIs. We should be careful to avoid this claim being reduced to the question of whether or not undetectable means uninfected.

A more important question might be how many sex partners can we have, in particular how many sex partners can we have unprotected intercourse with, and still be confident we are STI free? This question is not peculiar to those of us with HIV.

If the precautionary decision in this choice is to have an STI screen before our next partner, the risk decision is to defer testing until a certain time has elapsed, until we've had a certain number of partners, or until we get the itch. Crucially, the risk is not having an STI screen before we have another sex partner.

Another partner or decline?

So the risk involved in the first choice is bound up with the second choice, which occurs when we are faced with the opportunity for sex with a new partner: do we have sex with him or do we decline, defer or date him.

The profile of the rate at which we acquire new sexual partners is key to HIV and STI dynamics. This

continues to be a controversial and difficult statement to make in some gay communities.

HIV provides the sex averse in general and the homophobes in particular with a powerful stick with which to beat us. One response to the stigmatising claim that all gay sex is bad has been to claim that all gay sex is good, and that more gay sex partners is better. One of the leading mis-truths of HIV prevention has been that it does not matter how many men we have sex with, it's what we do that counts. Of course, *both* how many partners we have *and* what we do with them counts.

There is often a confusion here between sex and sex partners. The need to be sex positive is often read as a requirement to pretend having many sexual partners is entirely unproblematic. Of course it is not. Especially if we consistently choose not to have an STI screen between partners.

However, among gay men generally as well as gay men with HIV in particular, one of the most common reasons for being unhappy with our sex lives is that we would like *more* sex partners. How useful then, is it to simply tell gay communities (or any other communities for that matter) to reduce our number of sex partners?

We need a population goal which is more nuanced than everyone having fewer partners. In *Making It Count* that goal is articulated as the relationship between the number of sexual partners and the number of STI screens. This might allow for both an increase in sexual partners for some men and a reduction in harm among the population overall.

Silence or sharing?

The 3rd choice is whether we share our HIV and STI diagnoses with our sex partners, and discussion about sex that might flow from that. Obviously this choice has different potential consequences depending on if we have any infections.

If we and our partner do not have HIV and want to enter into negotiated safety agreements we must both have chosen to test and we must have disclosed those results.

In terms of impact on HIV risk and other harms, I think this is the choice about which we can be least confident of the outcomes. Depending on the harms we are talking about, disclosure is not the foregone better option. Depending on what kind of sex we are planning to have there may well be more to be gained from saying nothing.

It is also important to note that disclosure concerns not only HIV and that it faces in both directions. As well as choices about telling sex partners about infections before sex, there are also practical choices to make about telling former partners when we are diagnosed with an STI. If sharing is made a precautionary behaviour, we make a risk of silence.

Open or monogamous?

The 4th choice faces us if we have a regular sexual partner, and is whether or not with have sex with other people as well as our regular partner – in other words whether we have sexually open or monogamous relationships.

The presumption that gay men are unable to have monogamous relationships is one of the ways in which we are stereotyped, evidenced by the constant debate about the actual existence of gay monogamy. We are often deemed unable to have monogamous relationships and are then damned for not doing so. As monogamy is held up as an ideal from which we are excluded, it is unsurprising that we have developed ambivalent attitudes toward it.

The presumed moral superiority of monogamous relationships by people who would condemn homosexuality outright, has resulted in monogamy itself being suspect, part of an aping of heterosexuality by wannabe respectable queers.

However, there is nothing virtuous in monogamy in and of itself. Like Don Giovanni, I tend to think that it is more virtuous for a beautiful man to share himself around rather than selfishly limit himself to one partner. But like all the choices, the right decision can only be arrived at by consideration of the potential consequences for those involved, both their potential harms and their potential utilities, and by the other choices that accompany it, particularly discussion within the relationship and sexual choices outside it.

However, men in sexually open relationships *do* face a double STI risk because they are sharing their risks with their partner. They may also enjoy both the stability of a regular relationship and the excitement of new partners.

AI or other kinds of sex?

When we do have sex, the important choice is whether we have anal intercourse or whether we have non-penetrative sex. The message 'Use a condom every-time you have sex' carries the implicit assumption that sex means anal intercourse. Anal intercourse is a highly intimate act laden with meaning, including, perhaps particularly, when it occurs with new partners. This is precisely why many gay men prefer it not to feature in all of their sexual encounters. When men have sex together, anal intercourse is far from a foregone conclusion.

No condom or condom?

The decision to fuck or not is independent of but tied to the decision to use a condom or not. While there is a widespread assumption in HIV prevention that sex between men will consist of anal intercourse, there is also an increasing assumption that it *need not* feature condoms if partners are sero-concordant. However, there is no situation of anal intercourse in which a condom is not beneficial. It's simply that the potential costs of not using them vary.

In or on?

If we have intercourse or fellatio, we have the choice of ejaculation into the body or withdrawal before ejaculation.

Poppers or no poppers

In the UK there is an increasing consensus that poppers use increase HIV transmission probability when exposure occurs, so their use has become a behaviour of concern. The alternative is not

using them.

No PEP or PEP

And finally whether or not men who have been exposed take post-exposure prophylaxis will have a bearing on the rate at which men are acquiring HIV.

Choices are important. Decisions freely made are valued more highly than the same decision imposed on us. Although some people may try to deny us these choices, they will remain open to the vast majority of us on an ongoing basis.

It's common when the choices like these are made explicit for us to assume that a correct choice is being implied. We live in risk averse cultures. This does not mean that we do not take risks, but that we all attempt to manage the meanings of them. If a risk is identified there is an assumption that we should choose to eliminate it, either by ceasing to do it or by arguing it is not a risk. We tend to hear mention of adverse consequences of something we want to do as criticism or as a lecture. We seek to blot out or minimise any potential costs on the horizon so as to better justify our choices. Gay men are not peculiar in being highly sensitive to criticism or disapproval of our sexual choices, but we are perhaps less tolerant of it, often simply having no truck with the opinions of someone we think has judged us.

This makes it a challenge to raise awareness of what is at stake in the choices we are making and should make us hesitate before sharing our opinions rather than sharing our knowledge.

We need also be aware that people do not fall neatly into the risky and the risk free.

We can ask if our idea of the best sex is when we are Unconfident about whether or not we already have an STI. When sex is Immediate and with a new sex partner, when it is Silent, when it occurs within an Open relationship. When it features anal intercourse without condoms but with ejaculation into the body and with poppers, and when it is followed by nothing but crossed fingers.

Alternatively we can ask if the best sex is when we are confident we do not have an STI. Whether sometimes it is actually No sex, deferred sex or dated sex. When we do have sex is it best when preceded by disclosure and discussion, and when it occurs in a Monogamous relationships, is non-penetrative, or if it is penetrative featuring condoms and withdrawal, but no poppers, and when it is followed by PEP.

In practice lives tend not to fall like this. Instead we are faced with an on-going set of choices that each have the potential for both benefit and cost, utility and harm. Although we may make one or more of these choices for ourselves for the foreseeable future, other choices will need to be made each time an opportunity for sex arises. We mix and match choices based on our changing circumstances, and the minutiae of our day-to-day lives. Increasing the quality of people's choices is the point of HIV Prevention, not making the choices for people.

Most people in the UK think our HIV incidence is unacceptably high. But it's not the case that all gay men are happy with their sex lives. About a third say they are not. In this version of the epidemic, the messy, contingent day-to-day epidemic we all live in, the point of HIV prevention, if you want to all it that, is to move us all, individually and collectively, towards better sex with less harm.

The consultation draft of *Making It Count 4* is available on the Sigma Research homepage. Thank you for your attention.