Towards better sex with less harm for gay and bisexual men

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Good Afternoon

Sexual Happiness and HIV are Positively Correlated at a National Level

I'd like to start by linking two pieces of data from the EMIS survey, the Pan-European Gay Men's Sex Survey whose UK arm was supported by CHAPS.

This graph plots 38 European countries using two statistics. The proportion of men living in that country who were happy with their sex life along the bottom and the proportion who had diagnosed HIV up the side. You can see a clear pattern from the bottom left to the top right. Countries where more men are happy with their sex life tend to have a higher prevalence of diagnosed HIV. I didn't want us to find this pattern, it is uncomfortable and inconvenient. We've been controlling for various confounders, but the association is not going away.

The UK is here, just next to Luxembourg. Relative to other European countries we have a high prevalence of HIV, but only a slightly higher than average proportion of men happy with their sex life. In other words, the quality of our sex lives does not warrant the level of HIV we are seeing.

Here's the same graph with the old EU countries in red, the new EU countries in green and the non-EU countries in black. We can see that the countries of the old EU tend to have better sexual lives and more HIV, while the new EU and non-EU countries have fewer men happy with their sex life and less HIV.

If we exclude the 18 former communist countries, we are still left with a significant country level association between the proportion sexually happy and the proportion living with diagnosed HIV, so the explanation of the pattern is not simply that the Iron Curtain functioned as an Iron Condom.

There seems to be common agreement that there is too much harm arising from the sex lives of gay & bisexual men, and that this harm needs to be reduced. But at what, and whose, expense is this to occur?

What’s the goal?

I’m going to argue that making a reduction in HIV incidence our collective goal is not enough on which to build a common future. I believe we are in something of a stand-off or stalemate that is preventing us collectively getting to grips with HIV. On the one side is an uncomfortable alliance between homophobes and a public health imperative that insists on less harm at any cost to gay and bisexual lives. On the other side is a gay liberation past, and a gay leisure-sex industry present, that portrays the best gay sex life as being a Pornotopia that is a both a birthright and an obligation. This dynamic has resulted in a false choice between sexually happy populations with a lot of HIV or sexually miserable populations with little HIV. It is a dynamic which suggests we can only move up and down an axis that goes from bottom left to top right in the Figure 2 – it suggests that our choice is between more sexual happiness and more HIV or more sexual misery and less HIV. This is a false choice. We can, I believe, collectively move towards better sex with less harm. But we need to know where we are heading.

The Ten Choices

I’d like to briefly consider ten choices that face gay men, bisexual men and other men who have sex with men, and that they will continue to face in the future.

The ten choices are derived, described and analysed in *Making It* Count, the collaborative planning framework of the CHAPS Partnership that was launched at this conference last year. These are the primary choices that, taken together, will determine the shape of the future HIV epidemic.

Each choice involves choosing precaution, or choosing risk.

● The first choice is whether to test for STIs, including HIV if we have not already been diagnosed, or to put off testing. You can hear more about the potential role of home HIV testing in Session 1 this afternoon, ways to promote regular HIV testing in Session 2, about the delivery of screening services at a Pride event in Session 4 tomorrow and other ways to increase testing in session 6.

What is increasingly clear from research is that one of the main reasons men with undiagnosed HIV do not seek testing is that they are highly fearful of HIV, and that that fear is often based on ignorance of its treatability and stigmatised attitudes about what it means to live with HIV. So fear of HIV is killing gay men with HIV by preventing them from getting diagnosed and treated. A sobering message if anyone is still advocating for fear based campaigns.

● The 2nd choice is, if we are diagnosed with an infection, whether to treat it or not. The impact of treatment on prevention will also be debated in Session 2 this afternoon, and is the subject of today's closing plenary. The impact of treatment on sexual functioning will be explored in session 5 tomorrow.

There are no dedicated sessions about the other 8 choices but I hope they will crop up throughout our discussions about services, their delivery and integration across a range of settings.

● Choice 3 arises when we have opportunity for sex with a new partner – do we decline, defer or date him, or do we have sex with him;

● choice 4 is whether or not sexual partners share what they know of their HIV statuses, or not: in other words, whether they attempt to establish HIV sero-concordancy;

● choice 5 pertains to men in steady relationships and is whether or not they are sexually exclusive to that partner, or whether they have an open relationship;

● choice 6 arises when we do have sex and is whether or not to engage in anal intercourse;

● choice 7 arises if anal intercourse occurs and is whether or not we use a condom;

● choice 8 is whether ejaculation occurs outside or inside the body;

● the ninth choice is whether to avoid poppers, or whether to use them;

● and the 10th choice faces HIV negative men and concerns whether or not to take chemo-prophylaxis against HIV, either Pre- or Post-exposure.

Not all of these choices will be open to all men in the future, although most will be. The contribution of each of the choices to HIV incidence will vary across countries. However, in all countries the future of HIV depends on the availability of these choices and the ways they are made.

Diverse populations need diverse tactics

Marcel Proust wrote that the one thing more difficult than following a regimen is not imposing it on others. Authorities try to impose singular solutions on diverse populations and most of these tactics have advocates for their exclusive or near exclusive use. Homophobes such as the Pope suggest we all choose not to have sex. Promiscophobes such as Cliff Richard would like to see everyone in long-term monogamous relationships. Those who are appalled by anal intercourse would like all men to avoid it. Perhaps the most common insistence on a singular tactic is that

all men use a condom every time, advocated by safer sex experts who value promiscuity and public health officials who have a limited conception of the diversity of homosexual repertoires. More recently fierce advocates of test and treat have emerged.

Advocates of a singular tactic tend to dismiss other tactics as either unnecessary (because people only need follow their rule), ineffective (because they would not work every-time for everybody) or out of the realm of possibility (claiming men will never choose to decline sex, to not fuck, to be monogamous, etc.). However, the condom alone has not delivered us to the promised land of the best sex lives with the least harm. Nor will any one of these tactics deliver this for all men, with all partners, on all occasions.

Combination prevention

Combination prevention means acknowledging that people's circumstances differ, that there are multiple primary causes of HIV transmission, and that transmission can be interrupted at a number of points. It encourages us to consider programmes of work that enable individuals and couples to reject those risks which for them carry no utility, and to adopt those precautions that enable them to approach the things they value, with as much risk as they are willing to bear.

I do not know which of these choices are the right choices for all men in the future. So I cannot tell everyone to always use a condom, or to never have another sexual partner, or to test for HIV every year. What we do know is that the best sex will not always be: while in an open relationship, with a new sexual partner, without having STI screened since the last partner, in silence, including intercourse, without a condom, with ejaculation in the rectum, while using poppers. A series of these encounters is not the best sex life all gay & bisexual men are aspiring to. For a fuller picture of what the best sex life might look like for gay and bisexual men you can attend the Bad Romance session this afternoon.

Evasive and defensive tactics

HIV prevention has for some time focussed on those tactics which involve a product – take a test, use a condom and, more recently, take the pills. (In the future we hope to be able to add use a microbicide.) We might call these the defensive tactics.

What we might call the evasive tactics tend to be couched in terms of 'don'ts': don't have another sex partner, don't have open relationships, don't fuck, don't use

poppers. These choices HIV prevention work with gay and bisexual men tends not address. I think there are three main reasons why not.

The first is that in health it is usually easier to tell people do something than it is to tell them not to do something. We need to get round this by representing precautions as active choices and by promoting the benefits that are of value to gay & bisexual men. This means portraying declining sex, monogamy, non-penetrative sex and avoiding poppers as active choices that can result in time to invest in sociable and enriching pursuits; emotional security; clean, convenient, brotherly sex; and no headache.

Another reason we shy away from promoting evasive tactics is that some HIV risks make money. Poppers is an obvious example. Less obvious is that partner acquisition is the raw material of a gay leisure-sex industry that intertwines sex work, drugs, pornography, clubs, cruising websites, promotional advertising, lifestyle magazines, sex paraphernalia, saunas and fitness facilitates.

Casual sex, open-relationships and poppers are normative among gay communities and a considerable economy is sustained by them. The gay leisure-sex industry dominates our visual landscape of what it is to be gay, which is to have numerous sexual encounters whose only consequence is sexual satisfaction and social standing.

Unlike the tobacco-control lobby, HIV interveners do not lobby against the promotion of some HIV related risks, such as the provision of the means of acquiring new partners, the graphic representation of anal intercourse, or the sale of poppers. Instead these are things that have been defended from those who would deny the right to them all together.

So, a third reason we do not acknowledge these evasive tactics is that they are those homophobes have traditionally tried to impose on gay men. We need to get over this by not *telling* people what to do (or what not to do). We need to stress our belief in men’s right to take risks within the law and that our defence of that right is not the same as our endorsement of taking the risk. Otherwise we are simply competing with other authorities in claiming dominion over men’s bodies.

Another sex partner?

A nations’ Homophobic response to HIV results in a defensive backlash by gay communities. Sex is not simply a matter of physical relief. How we have sex says something about who we are, both to others and to ourselves. Having sex is a way

of being as well as a way of doing. When you threaten my way of having sex you threaten my very being.

When under threat we retreat to black-and-white positions. When some say all gay sex is bad, we respond by saying all gay sex is good, and more gay sex partners is better. One of the tenets of the gay liberation movement of the 1970s that so informed the gay response to HIV in the 1980s was that having gay sex is liberating, and the more sex partners you had the more liberated you would be. When the closet is the dominant source of harm to our sexual lives, this strategy makes sense. But when sexually transmitted infections are a major source of harm it is counter-productive.

Even in the 1990s the gay safer sex movement was encouraging men to increase sexual partner acquisition, as long as they always used a condom. This approach was and is supported by the gay leisure-sex industry which portrays the greatest sexual happiness as being the same as the greatest number of sexual partners. However, this industry has not delivered wide-spread sexual happiness to gay and bisexual men. It has improved it (by providing sexual contact) but in the process has also generated a mass sexual performance anxiety and wide-spread sexual misery over our inability to live in Pornutopia.

Gay and bisexual men greatly over-estimate how many sex partners other men have. Our constant exposure to images of successful and happy cruising and contracting gives us the impression that everyone is at it all the time. Subsequently, the majority of men think they are less promiscuous than others and that they contribute less to population risk than they in fact do.

We need to acknowledge that the best sex life for gay & bisexual men is not the Pornotopia portrayed by the gay leisure-sex industry. Frequent sex does bring greater sexual happiness but more sex partners also bring greater harm. The direction of travel should, therefore, be better sex with fewer partners.

Current HV prevention practice seems not to distinguish the value of different sexual partners. All sexual partners are equally risky and equally valuable. However, different partners do have different values. The fewer sexual partners we have, the more valuable each becomes.

We could both reduce harm and increase the quality of our sexual lives by eliminating sex that carries risk but has little utility. This includes sex we regret, or that takes time that could be more happily invested in some other activity. Another

sex partner is not always the best decision and we need to move away from our fear of expressing this.

There are many men with large numbers of partners who are unhappy. And many unhappy men who want not more partners but a stable, steady, regular partner. Many of them would like to be monogamous.

Lack of regulation

We know that education, information and services can help men to make capable, informed choices. But someone capable and informed will not always make a precautionary choice because capability and information are not the only things that influence choices. We need to recognise the increasing structures in the provision of goods and services in the gay leisure-sex industry that allows and encourages men to take risks.

Despite the efforts of local projects and international projects such as Everywhere, many sex-on-premises venues continue to show bareback porn, or fail to provide sufficient soap and water to wash away faecal bacteria before returning to the bar, or do not supply condoms or precaution positive imagery. Condoms in gay pornography are less normative than a hard-hat on a building site, sex on premises venues are less regulated than a local restaurant. Workforce health and safety protection in the gay leisure-sex industry is weak. Service quality regulation is variable. We need to challenge these situations by acknowledging and defending the legitimacy of these industries and our expectation that they comply with existing legislation on health and safety of the workforce.

HIV-ogenic environments

The 'othering' of HIV risk drives us to seek explanations in the character and failings of individuals, when in fact our choices are strongly, some would say predominantly, determined by our circumstances and our surroundings. Making the problem 'those risky men' prevents us from identifying and altering the risky environments we live within. The 'obesogenic environment' is now a common concept in accounting for the increasing trend towards obesity, especially among poorer people in richer countries. Why are we so resistant to acknowledging the 'HIV-ogenic' aspects of some gay socio-sexual structures and institutions? Why is homophobia the only structural facilitator we seem willing to identify?

We identify fast-food outlets as being an issue for obesity, but we turn a blind eye to the role of fast-sex outlets in STIs and HIV. Are we frightened of the vested business interests, are we afraid of appearing to get into bed with homophobes, or are we not wanting to acknowledge these are the risks we ourselves choose to take? I suspect all three are in operation, along with other explanations. I know that we need to understand and overcome these obstacles if we are not to inadvertently promote risks to men whose sex lives would be better without them.

A homofuture is inevitable

Gay men, bisexual men and other men who have sex with men are not simply an HIV risk group. Love and sex between men: is natural and healthy; is part of every tradition; in every country; it is robust; has and always will be with us; it is warm and intense; fun and pleasurable; it is sociable; it helps bind the social fabric; fosters valuable skills; and is a precious experience; it brings honour and reward; comprises sacred acts; and is a highly correct moral choice. The future cannot but contain something so valuable.

HIV, on the other hand, is just a virus. Still a very serious virus, but nothing more.

Outro

Returning to the data we opened with, we cannot co-ordinate our activities unless we share sufficient goals and aspirations. Stressing the singular goal of reducing HIV at any cost aligns us with the enemies of gay and bisexual men and fosters suspicion, distrust and reaction. Attempting to impose a singular risk reduction tactic on a diverse population also causes reaction and it fails to exploit the range of precautionary tactics available. Making everyone else's decision for them is not going to work, since we can't all decide which decision everyone should take.

In terms of our graph, it's not acceptable to move our countries down if they are also moving to the left (that would be to move towards less harm but worse sex). Nor is it acceptable to move them to the right if they are also moving upwards (better sex but more harm). Where we want to be heading is to the left and downwards, that is towards both better sex and less harm.

We desperately need a common goal on which those of us concerned about both HIV *and* the happiness of sexual minorities can collaborate. Not simply collaboration between agencies, authorities and activists, but between those speaking and those on whose behalf we speak. A desire to see less HIV is not enough. Our common common goal needs to be the best sex with the least harm. We need to know where we are heading. Thank you for your attention.