Keeping it safe: maintaining gay safe sex practices in the light of treatment for HIV.

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The HIV epidemic in Australia is emerging as one that is quite distinct from almost anywhere else in the world. Some of the distinguishing features of the Australian epidemic are important in discussing the impact of antiviral therapy for HIV on sexual risk behaviour.

Some of the key features of the Australian epidemic are that:

1) HIV is contained within the population in which it was first identified – gay men – (with over 80% of all diagnoses as well as of new infections);

2) combination antiretroviral therapy is subsidised by the Commonwealth government under the Pharmaceutical Benefits Scheme, making it widely available; and

3) the majority of people with HIV are in fact on treatment (73.6 percent), with an even greater majority having been on HIV treatments at some time (86.5 percent).

"Keeping it safe: maintaining gay safe sex practices in the light of treatment for HIV", suggests, or at least invites us to assume that HIV treatments have changed gay men's sexual behaviour, or have the potential to do so. I'd like people to be aware that this is quite a powerful assumption, and one that permeates a lot of discussion and reporting. However, on the other hand, it is naïve for us to deny there is a connection between these two things. It is emerging in Australia at least, that HIV treatments, in a round about way, are, in fact, having such an impact. [See info box on additional data].

Antiretroviral therapy has changed the landscape significantly since 1996 and our education programs need to evolve to encompass this.

Challenges

There are several challenges that are relevant to this discussion. Firstly, there has been a shift in the relationship of gay men to the epidemic. This was identified a few years ago and although intensified by the availability of new treatments, was in a sense occurring anyway. It is important to point out that the epidemic in Australia has been quite stable for some time. As Judge Edwin Cameron pointed out on his recent visit to Australia, the annual HIV infection rate in Australia is surpassed in South Africa about every eight hours.

Since the mid-1990s there has been an emerging sense that gay men's relationships to the HIV epidemic were changing and there was no longer a generalised sense of epidemic-generated community crisis even among PLWHA and for increasing numbers of younger men in particular, it had never existed anyway.

The term "post AIDS" has been used to describe these multiple and fragmented responses. However, it has also been contested as a misleading term by some educators who see it as signalling inaccurately that the epidemic is over. A preference emerged for "post crisis" as an alternative, but that concept too has been challenged by some PLWHA. The result has been an ongoing public discussion around what the passing of social crisis means, as distinct from ongoing, individual experiences of personal crisis, and of the implications this has for gay cultures generally, PLWHA specifically and the services offered by AIDS organisations.

A second challenge is the behavioural and cultural trends that we need to understand more fully. The most important of these is the steady increase in unprotected sex with casual partners reported by gay men in Sydney. The *Sydney Gay Community Periodic Surveys* that are conducted every six months have identified a slow but steady increase in reports of unprotected sex with casual partners over the period from February 1996 to February 2000. This increase in unprotected sex has been reported in both positive and negative men but among positive men the proportion is greater. However, I should also mention that in other locations where Gay Community Periodic Surveys have been conducted, and the results are available, there has been no increase in unprotected sex with causal partners. This increase in unprotected sex has not yet led to any increase in the annual number of new HIV infections. There are a few theories about why not, and these theories do not necessarily contradict each other. One is that much of this is made up of sex between positive men; another is that it is negotiated unprotected sex between HIV negative gay men; or that it is the result of high treatment uptake and a corresponding decrease in viral load at a population level.

The third challenge is the impact of treatments and clinical markers on gay men's risk assessments around HIV and the different ways positive and

negative men are incorporating knowledge about treatments into their sexual behaviour. As HIV is increasingly re-medicalised, positive and negative gay men are not necessarily interacting on the same terms or understandings. (However this is not to suggest that positive gay men automatically have a high awareness of treatments and negative men don't.)

Ever since new treatments for HIV became available in Australia in 1996, there has been an assumption that this would affect negative gay men's decision-making because they would not view the spectre of becoming HIV positive as such a daunting or deterring prospect as it had been in the past. In fact it has become commonplace to assume, with no evidence, that any change in sexual behaviour among gay men is automatically linked to new treatments. There *is* now some evidence that a connection exists between what is referred to as "optimism" around treatments, or HIV generally, and sexual practice, with men who reported any unprotected casual sex in the previous six months more likely to have a positive attitude towards treatments. [See info box on additional data].

However, the number of men who were considered "optimistic" using this scale was very small. The large majority of men are quite sceptical in relation to HIV treatments.

This does not mean of course that gay men who are more sceptical about HIV treatments do not have any unprotected sex – they may do. Also, it is impossible to draw any conclusions about the direction of this relationship between treatments optimism and unprotected casual sex, or to assume a causal connection.

More recent qualitative research into the nature of this relationship has suggested that HIV treatment, or more particularly HIV viral load, is now having an impact, albeit indirectly, on sexual behaviour among positive gay men, and that this, in turn, has an impact on negative gay men. Pharmacological interventions such as HIV therapy and viral load testing are changing the meaning of living with HIV and this has direct as well as indirect effects on the nature of the epidemic, including the sexual culture. And if cultures or norms of unprotected sex between positive men are emerging, it is important that negative gay men are cognisant of this. Recent research conducted by Rosengarten at the National Centre in HIV Social Research (NCHSR) seems to suggest that a sexual culture is emerging in which both positive and negative men are engaging, but on changed and different terms. So, if being positive has changed in ways not yet evident to many negative men, this may be played out in sexual scenarios in ways that may not be based on a shared understanding of who is doing what and why?

In terms of where and how new HIV infections occur, research also indicates that in Sydney, at least, new infections occur in at least two contexts. The seroconverters' study data suggest that in the case of regular partners the first six months in serodiscordant relationships are when new HIV infections are more likely to occur. And in casual sex, new infections tend to occur in particular contexts involving a *grouping* of factors including engaging in a range of so-called 'esoteric sexual practices', the use of recreational drugs and alcohol, attendance at sex venues (where there is a crossover of men of different HIV status), and being closely involved in the Sydney gay communities. It should be noted that none of these factors *alone* is associated with seroconversion.

Another important challenge I would like to mention here is the role of post-exposure prophylaxis because there has been a great deal of discussion about its potential detrimental impact on safe sex culture. In one Australian state, NSW, post-exposure prophylaxis, or PEP, has since late 1998 been recommended and paid for by the state for non-occupational exposure to HIV.

PEP however, is considered such a challenge to gay safe sex practices that there has been a real reluctance to promote its availability. Although that may now be changing. The task for us as educators therefore is to develop ways of thinking about PEP that incorporate it into an overall prevention strategy without undermining safe sex practices.

An overarching challenge for HIV education and prevention for gay men is to incorporate it into a broader framework of sexual health, particularly as specific funding for HIV programs decreases.

Silences

There are a number of silences that need to be broken, or problems solved, in relation to maintaining gay safe sex practices. The first is related to the issue just mentioned – PEP. There has been such a silence around it that few people know of its existence or its availability.

Another silence is related to negotiating around HIV status in casual encounters. Although this is a difficult or flawed strategy for HIV negative gay men, it is something that happens. However, disclosure of HIV status is still relatively uncommon with less than 40 percent of gay men reporting that they discuss HIV status with any casual sexual partners.

Third, is the silence around assumptions made by positive and negative gay men about the HIV status of their sexual partners, which influences behaviour.

Fourth, is the silence around unprotected positive/positive sex. There are significant barriers to discussing this in educational materials, not the least of which is from funding bodies.

And finally there is the silence around responsibility for safe sex and the prevention of

HIV transmission among gay men. This is quite urgent as the law is being used increasingly to determine this, and the laws related to HIV transmission are different in different states.

In terms of how these issues are being addressed, the research around contexts of seroconversions has been pivotal in our development of education programs for gay men. A good example is the focus on relationships – serodiscordant relationships and Negotiated Safety for negative men, which have formed an important part of our work for a number of years now.
Our current work plan and the work plans of our member organisations also feature specific campaigns for gay men on travel and sex venues which are known to be important contexts of seroconversions and risk behaviour, as well as assumptions about HIV status, and individual risk assessments, made in casual sex situations.
The shift in the relationship of gay men to the epidemic has also been an important consideration in our work, and there have been at least two campaigns over the past few years that have dealt with this issue specifically.
Information on PEP is provided as part of all prevention campaigns for gay men, in the state where it is available, and a specific, targeted promotion of PEP will occur in the near future.
For the future though, we still need to do more work on exploring how information about treatment for HIV is incorporated into gay men's thinking, both positive and negative, and how this is played out. This may be our best chance, in Australia at least, of maintaining gay safe sex practices for the future.

This is a version of a paper presented as part of the community program at the XIII International AIDS Conference.

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More data on gay men and risk

Dean Murphy

Prior to the Durban conference much attention had been given to reports of increasing HIV infections among men who have sex with men in San Francisco. These were based on data emerging from anonymous testing sites (ATS), where HIV incidence had increased from 1.3 per cent per year in 1997 to 3.7 per cent per year in 1999. This increase can now be detected more accurately (and applied to stored samples from as far back as 1996) by using the new highly sensitive/less sensitive HIV test. This is also called de-tuned ELISA/STARHS (Serological testing algorithm for recent HIV seroconversion), a test which can distinguish an HIV infection during the last four months, and from which annual HIV incidence can be estimated. The use of this test at ATS explains why an increase was not seen in sentinel surveillance at the municipal STD clinic from 1995 to 1999, although HIV incidence at this site remained at a constant high rate of five percent per year. Men presenting at ATS may be more representative of gay men than those attending STD clinics so it is possible that overall an increase in HIV incidence is occurring in this city.

Data showing increasing HIV incidence in Ontario, Canada were also presented in Durban. The POLARIS study looked at repeat HIV testers in this province to ascertain HIV incidence density. Ontario is uniquely able to perform this kind of analysis because of its system of centralised semi-identified HIV testing that enables anyone who has had a prior HIV test to be identified as a seroconverter. Among men who have sex with men there was a downward trend in the period 1992 to 1996 (from 1.9 per 100 person years in 1992 to 1.0 per 100 PY in 1996). However from 1996 this increased to 2.07 per 100 PY in 1999. This increase occurred in all age groups. In the 30-39 year age group HIV incidence was greater than three percent. (An incident rate such as this, if continued, would lead to HIV prevalence rates of 40-50 percent by age 40.) Incidence also increased among IDU but not among heterosexuals.

There were several papers and posters looking at the impact of HAART on behaviour – mostly related to gay men and other men who have sex with men.

A collaborative poster looked at the international differences in "HIV optimism" and sexual risk behaviour in Sydney/Melbourne, Vancouver and London. In *all* these cities, only a small minority of men expressed optimism with regard to HIV as measured by the scale developed by the National Centre in HIV Social Research. (Van de Ven P., Crawford J, Kippax S, Knox S & Prestage G, "A scale of optimism-scepticism in the context of HIV treatments." *AIDS Care*, 12, 171-176: 2000. Also reported in *National AIDS Bulletin* vol 12, no 6, 20-23:1999) There were however differences between these cities when comparing findings about optimism with sexual behaviour. In Sydney and Melbourne there was an association between optimism and unprotected sex with casual partners in both HIV positive *and* negative men. In London this association only held for HIV negative men. In Vancouver there was no such association.

Another poster by the London group looked at particular items related to "optimism" (rather than the whole scale) and found that although both HIV positive and negative men who were optimistic (in the light of improved treatments) were more likely to report unprotected sex with a casual partner of unknown HIV status, there was an overall increase in the percentage of men reporting unprotected sex with casual partners. This was seen in both those who were considered optimistic (the minority) *and* those who were not optimistic (the majority). The recent increase in UAI with casual partners seen in London cannot therefore wholly be explained by an association with optimism. (It should be noted however that the association between optimism and behaviour was never suggested as a causal one.)