

HIV Education and Health Promotion Responses to the Swiss Statement.

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This talk is an attempt to outline some possible HIV education and health promotion responses to the Swiss Statement.

I'd like to acknowledge Colin Batrouney, Simon Donohoe, and many others who I've spoken to over the last few days for helping develop some of the thoughts in the presentation. But, of course any errors or omissions are mine.

Responses

- Direct responses
- Where else might the Swiss Statement lead us?

Some of what I'll cover here will be a direct response to the advice of the Swiss Statement, but, I'll also be making some suggestions about where else a response could lead us.

Now, after hearing the previous speakers, you'll probably appreciate that developing any response to the Statement is complicated by the fact that almost all aspects of the Statement are contested.

Although there is agreement that there is strong evidence about the relationship between an individual's viral load levels and their infectivity, I think everything else about the **basis** for the statement is contested!

Debate

- Degree and durability of benefit
 - Breakthrough viral blips
 - Breakthrough genital shedding of HIV
 - Intermittent STIs (eg. Herpes)
 - Treatment failure & raised viral load between clinical visits

There has been disagreement about the **degree** of benefit from successful ART in reducing sexual transmission risk, and also disagreement about the **durability** of this benefit.

Questions

- Is transmission possible at *any* level of viremia?
- What about anal sex?

There has also been debate about whether transmission is possible at **any** level of HIV viremia – or whether there is a viral load level below which transmission is just not possible.

And, in Australia and other countries with large gay epidemics, there have been concerns raised that there is not enough data to establish whether anal sex is in a different category of risk to vaginal sex – even in the context of undetectable viral load - and should therefore be excluded from the Swiss Statement's advice.



So, if the role of HIV education is to interpret scientific data and understandings about biology, and to use these to craft advice for our communities, then responding to the Swiss Statement presents some challenges!

So, what about a direct response to the Swiss Statement? – Well, in July this year, an Australasian statement in response was published on the ASHM website.

**Australasian statement on HIV
antiretroviral therapy and infectiousness**
www.ashm.org.au/news/334

Consistent use of effective antiretroviral therapy (ART) will, in most cases, lead to an undetectable viral load (VL), as measured in blood, semen and vaginal fluids. As a result, the average viral load of the community of people living with the human immunodeficiency virus (HIV) will be reduced. By reducing the VL, ART will also complement the benefits of consistent condom use and effective sexually transmitted infections (STI) detection and treatment, in preventing HIV transmission that may otherwise occur due to condom failure. However, there are no data to suggest that a population HIV prevention strategy based solely or predominately on the use of ART and associated with a reduction in condom use, will lead to fewer people becoming infected in the Australian and New Zealand populations, especially in the context of rising rates of STI.

This statement is a joint response issued by the following organisations:

- Australasian Society for HIV Medicine Inc. (ASHM),
- National Centre in HIV Epidemiology and Clinical Research (NCHECR),
- Australian Federation of AIDS Organisations (AFAO)
- National Association of People Living with HIV/AIDS (NAPWA)

In this response ASHM and the other signatories – The NCHECR, AFAO and NAPWA, have taken the position that – at a population level – ART alone will not lead to a reduction in HIV transmissions, so consistent condom use is also required.

The Australasian response is not inconsistent with the Swiss Statement, which in fact did not remove advice about continued use of condoms, however, the Australasian response has been more cautious about the potential benefit of ART in reducing infectivity, and therefore the risk of HIV transmission when condoms are not used.

I know that some here today think that the Australasian response has been too conservative, and, hopefully we'll have time to discuss that in a few moments.

But, what did the Australasian Statement say?

Australasian statement on HIV antiretroviral therapy and infectiousness

www.ashm.org.au/news/334

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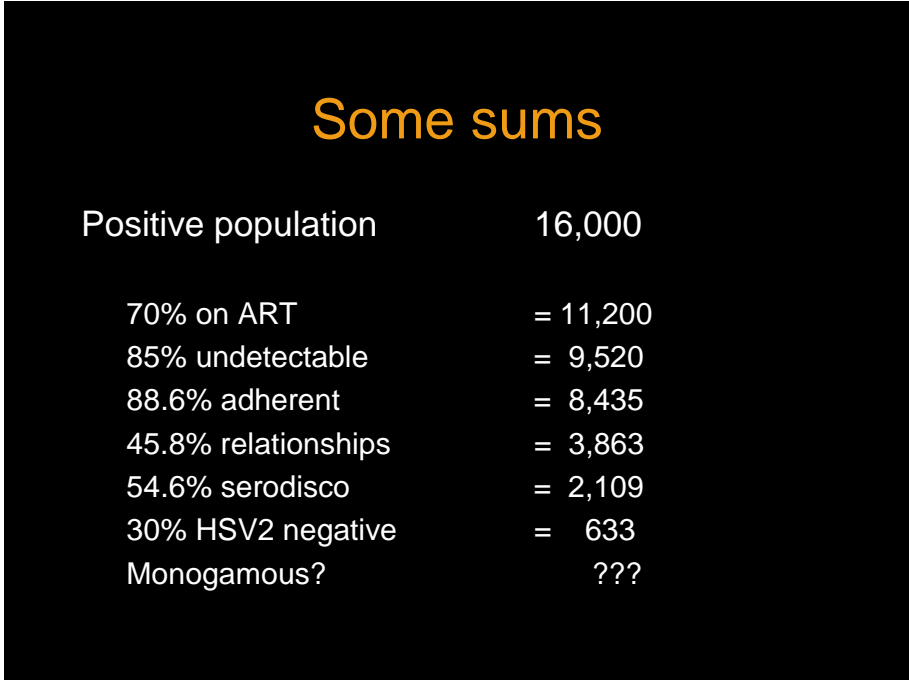
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In addition to this headline statement, the ASHM website has background papers on various aspects of the Swiss Statement. The URL is there if you'd like to look it up.

But, apart from a broad public statement like this, what does a response to the Swiss Statement mean for our work with people living with HIV and at-risk communities in Australia?

Of course, responses to the Statement in our work with **individuals** and **communities** will need to be more nuanced than a broad statement like this.

But, first of all, I would suggest that among people with HIV in Australia, the **number** of people who would fit the criteria required by the Swiss Statement is actually very small.



Some sums

Positive population	16,000
70% on ART	= 11,200
85% undetectable	= 9,520
88.6% adherent	= 8,435
45.8% relationships	= 3,863
54.6% serodisco	= 2,109
30% HSV2 negative	= 633
Monogamous?	???

I won't read that out, but, the point is that if you consider how many of the positive population actually meet the narrow criteria of the Swiss Statement, you're left with a very small number.



So, because the size of this audience is so small, there probably isn't going to be a social marketing campaign targeting them.



But, doctors, sexual health nurses, counsellors, treatments officers, and HIV educators will need to field questions from people who do meet the criteria of the Swiss Statement – if they are not already doing so.

Those workers will have to address the **specific** situations of their clients, and, apart from considering the Australasian response, they will need to address issues like adherence, viral breakout, STI exposure risk and more.

We will also need to work with other positive people who don't meet the criteria of the Swiss Statement, but who may be wondering what relevance the Statement has for them.

We will also need to address the broader contexts within which sex happens, including sex in casual settings, where STIs prevalence is high. The capacity for this Statement to be misinterpreted and applied to settings beyond it's intended scope is real – and possibly dangerous – although we are not yet sure how dangerous.

And, rather than just dismissing the Swiss Statement, if we are to be credible, then this work also will need to engage with the content of the Statement, and include clarifying information about the relationship between viral load and transmission probabilities, particularly in relation to factors where transmission risk is increased.

And, this is where our response gets more complicated.

Concerns have been raised that the impact of the Swiss Statement will be that positive people on treatments abandon condom use on a large scale.

Game Over?

Now, it will be important that researchers monitor for any such effect, but I think that a sudden **big** change in behaviour is unlikely.

I think it's unlikely because the general relationship between viral load and infectivity has been known for a long time.

Clinical Markers and Risk Reduction Strategies

We have also known for a long time that a significant proportion of gay men have already been using this understanding, combined with information about clinical

markers of HIV, such as viral load, to inform the development of **risk reduction strategies** - such as decisions about **whether** and **when** to use condoms, and strategic positioning.

And, although there is less data, this is probably also true for serodiscordant heterosexual couples.

The work that first documented this practice was done by Marsha Rosengarten, Kane Race and Sue Kippax - and many other Australian researchers have built on this work over a long period.

The development of such strategies in gay men's sexual cultures in response to new understandings about HIV has a long history – it dates back to the adoption of condoms for anal sex as a risk reduction alternative to abstinence.

Researchers like Michael Hurley and Sue Kippax have noted that such responses usually precede responses from health promotion and policymakers.



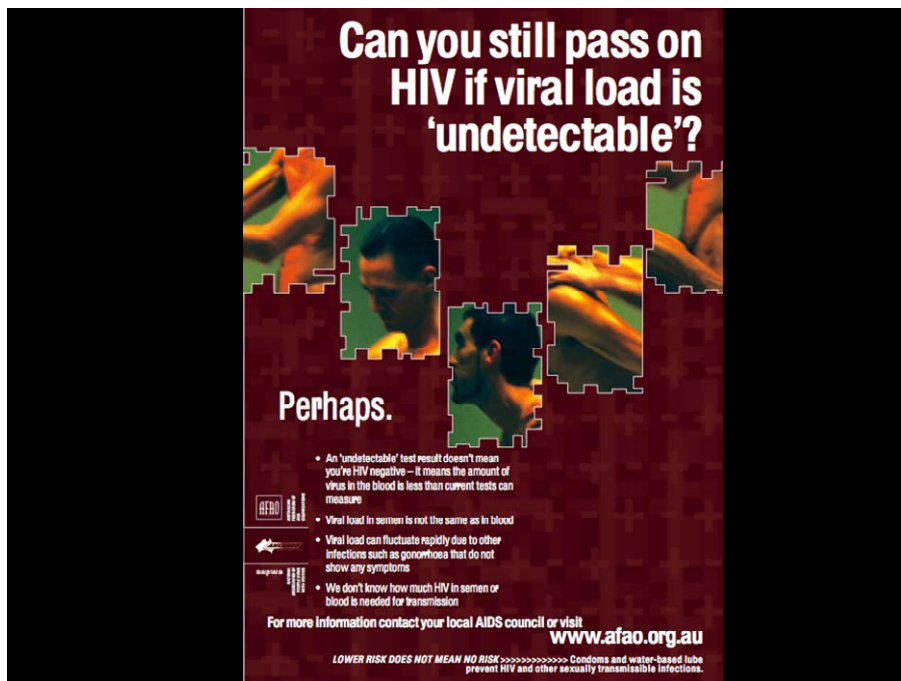
Health Promotion Responses

So, what about health promotion responses to these developments?

Well, for a short period a few years ago, we did do work that addressed these issues.



In 2001, ACON's *Consider This* campaign did go there. I think Brent Allan led the development of this campaign.



Then, in 2002, the AFAO / NAPWA *No Worries?* campaign was implemented nationally by AFAO, the AIDS Councils and PLWHA organisations. The development of this campaign was led by Dean Murphy.

But, I think that, with the exception perhaps of some of ACON's work, there has not been a lot of attention to this space in social marketing until very recently.

Colin Batrouney at the Victorian AIDS Council has developed a new campaign in this area - the '*Protection*' campaign.

[And – if anyone is faint of heart, you might want to cover your eyes at this point]



[at the left are the key messages on the poster; this one was produced as a full-page ad in the gay press, but it is bit hard to read on the screen]

But, why did we reduce our focus on work that addressed gay men's use of risk reduction strategies?

Rises in HIV Diagnoses

Around the time that AFAO and the AIDS Councils were running the *No Worries?* campaign - in 2002, it became apparent that the data on rises in HIV diagnoses was looking like a national trend, rather than just a rise in one or two states.

The response to this new situation of rising diagnoses was a renewed emphasis on promoting condom use, and, although risk reduction work in relation to viral load continued in peer education and outreach settings, it pretty much disappeared from social marketing campaigns.

But, gay men's use of risk reduction strategies has not gone away, and, I would suggest that even without the release of the Swiss Statement, that we should have been going there again.

Recent Research

- Different responses to undetectable viral load
 - Different understandings?
- Relationship agreements
- Serosorting
- Intensive sex partying

Recent social research data has shown that some of the ways that gay men are deploying risk reduction strategies may be increasing HIV transmission risks.

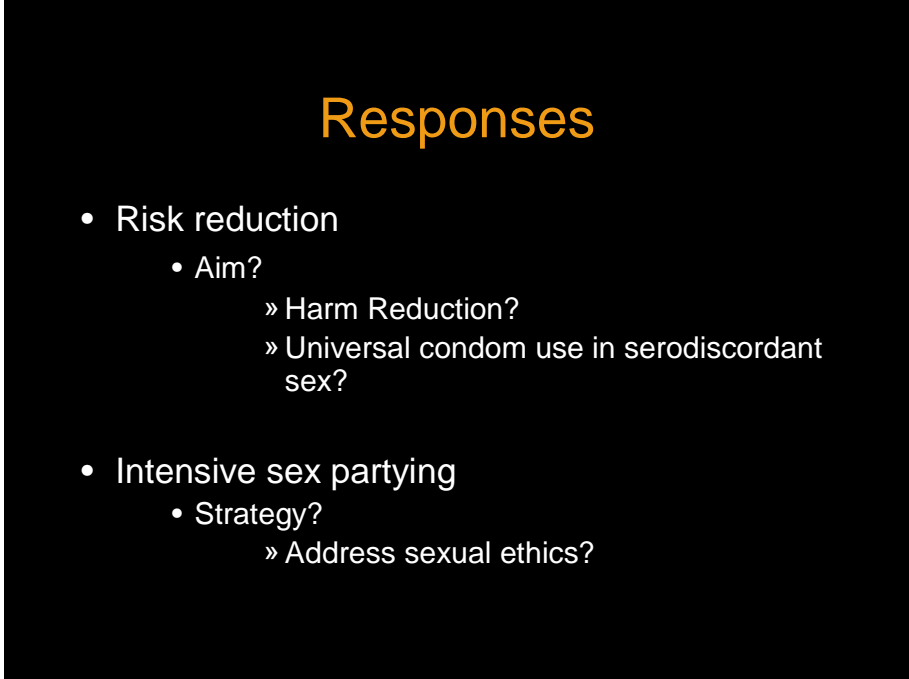
Recent work by Garrett Prestage and others - in an article currently under review - has suggested that HIV positive and HIV negative men in serodiscordant relationships may have different understandings of the role of viral load in decisions about condom use and strategic positioning.

In this analysis, positive men were just as likely to engage in UAI when their viral load was detectable **or** undetectable, and strategic positioning was not used when viral load was detectable.

These surprising findings trouble one aspect of the advice of the Swiss Statement - that it should be the HIV negative partner that decides whether condoms are used at times when the positive partner's viral load is undetectable.

Other recent work by Garrett Prestage, Iryna Zablotska and others has documented other changes in areas like relationship agreements and serosorting, in directions that may be increasing HIV transmission risks.

Also, emerging understandings of risks in cultures of intensive sex partying will require careful responses – probably including addressing questions of sexual ethics.



Responses

- Risk reduction
 - Aim?
 - » Harm Reduction?
 - » Universal condom use in serodiscordant sex?

- Intensive sex partying
 - Strategy?
 - » Address sexual ethics?

So, perhaps the Swiss Statement provides an impetus for us to address issues like these.

If we do go there, there will be questions about whether our aims should be to promote a return to condom use in all contexts of serodiscordant sex, or whether a harm reduction approach is more realistic – but, that is a whole other debate.

Responses

- STIs
 - More innovative responses for highly sexually active men?
 - » STIs chemoprophylaxis?
 - » Presumptive treatment?
- Reduce undiagnosed HIV
 - » Trial rapid HIV Testing?
 - » Symptoms recognition campaigns

Additionally, Paul Kidd has recently suggested that part of our response to the Swiss Statement should be to look at new strategies to reduce the prevalence of STIs, and also to work on better addressing areas where HIV transmission risks may be higher than UAI involving people on ART.

Recent work by David Wilson and others has highlighted the proportion of new HIV transmissions that may be happening from men with undiagnosed HIV infection – these are estimated to account for 30% of new infections.

Now, rising HIV infections, significant numbers of undiagnosed, and rising rates of serosorting among presumed HIV negative men, creates a dangerous mix.

Where will the next 1,000 infections come from?

It may be that more attention to these areas of our work will result in a bigger reduction in new transmissions than our fussing about whether 10, or 40, or 400 copies of HIV per ml might enable transmission to occur.

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