

Risk reduction strategies for anal sex with casual partners.



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There is evidence that gay men are increasingly making individual risk assessments in relation to unprotected anal intercourse (UAI) with casual partners. This discussion paper draws on recent qualitative and quantitative research on the issue of HIV risk assessment and management by gay men, and the factors that influence this.

Background

From an epidemiological perspective, HIV transmission in the community is influenced by two factors:

- 1) the number of contacts between infected and uninfected; and
- 2) the infectivity of the agent, or the risk of transmission per contact.

Among gay men this basically means the number of occasions of unprotected anal sex between HIV-positive and HIV-negative men, and the risk of HIV transmission occurring during those occasions.¹

Almost all education campaigns to date have focused on the former—minimising occasions of unprotected sex between men of different HIV status—but very few (with the notable exception of campaigns on “withdrawal”) have addressed individual risk reduction strategies employed by gay men in relation to unprotected anal sex.

It is also becoming clear that new treatments and medical technologies are having an impact on risk assessment and sexual practice. The introduction of new treatments around 1996 occurred around the same time as increases in HIV risk practices among gay men. A scale of optimism-scepticism in the context of new HIV treatments was developed in 1999. In administering this scale as part of the Gay Community Periodic Survey in Sydney over the past two years it has been found that there *is* an association between optimism (that antiviral therapy leads to reduced infectivity) and sexual risk practices. This is true for both HIV-positive and HIV-negative men. This association is not suggested as a causal one.

Insertive/receptive roles in anal sex

The estimated risk of HIV transmission for insertive versus receptive risk is not equal. According to the *Guidelines for the Management and Post Exposure Prophylaxis of Individuals who Sustain Nonoccupational*

Exposure to HIV, ANCAHRD/CTARC Bulletin, February 2001, the risk of transmission as a result of *receptive* anal sex is 1:125 to 1:31 or approximately three per cent. For *insertive* anal sex the risk is 1:3333 to 1:1111 or approximately 0.1 per cent. Based on these figures it is obvious that there is much greater risk if the negative partner is receptive in serodiscordant anal sex.

Despite the fact that there is a risk of HIV transmission during unprotected anal sex if the other partner is HIV-positive (whether that partner is insertive or receptive), it would appear that many gay men believe, quite correctly, that there is greater risk to the receptive partner. It seems logical to assume that the existence of published guidelines for PEP, for example, stating the relative risk of receptive and insertive roles will only increase the perception that the degree of risk is different. The recent *Touch wood...* study found that some positive men are deliberately adopting the receptive position of anal sex as a risk reduction strategy for HIV transmission.²

Analysis of data collected through the Gay Community Periodic Survey in Sydney from 1996 to 2000 also found that patterns of HIV-positive/receptive and HIV-negative/insertive roles in anal sex are, in fact, risk minimisation strategies rather than sexual preference alone.³

Viral load and HIV transmission

Available research provides evidence that viral load affects risk of transmission—at least in some contexts. A study among heterosexuals in Africa found that viral load is the chief predictor of risk of transmission, and that transmission is rare in situations where viral load is less than 1,500 copies. (This study was looking at both male and female positive partners in serodiscordant relationships.)⁴ There is not the same amount of evidence that viral load lowered by HIV treatments means reduced infectivity in the context of anal sex. However, an analysis of the Swiss HIV Cohort Study found that HIV-positive men with suppressed viral load as a result of antiviral therapy, also have very low levels of viral load in semen, which may lead to lower rates of sexual transmission. (This group cautions that HIV can still be sexually transmitted through provirus even if there is no HIV RNA in semen.)⁵

The *Touch wood...* study found that there was, among some men, a belief that viral load was related to transmission, and among positive men, a belief that an undetectable or low viral load may provide for a reduced sense of infectivity. This was most evident in terms of the notion that a high viral load means greater infectiousness.

Disclosure/assumptions about HIV status

The notion of shared responsibility (of HIV transmission) has been an assumption operating among educators for some time, and has been emphasised through various education campaigns. It would seem that there is now no real understanding, or sense, of shared responsibility among gay men and that on the whole HIV-positive men are shouldering the burden for managing risk, even within serodiscordant relationships.

Data from the Gay Community Periodic Surveys in five Australian cities show that disclosure of HIV status to casual sex partners is rare. Less than 40 per cent of men in all cities reported that they disclosed their HIV status to *any* casual partner in the six months prior to completing the survey. A similar proportion reported that *any* casual partner had disclosed his HIV status to them.

Recent focus test results for another ANET campaign emphasise the ongoing need to inform HIV-negative men that HIV-positive men will not necessarily disclose their HIV status to sexual partners.⁶

"I don't think men who know they're positive should have unsafe sex with others when they don't know their status."

(HIV-negative, Melbourne)

"Statements like these could be good for sweet young things who believe everybody is as caring and considerate as they are. I was one of those new to the scene, but I soon learnt."

(Brisbane)

"No I don't normally [disclose my positive status]. No one does unless they're asked. There should be more about the issue of when to disclose. It can be pretty hard to do five months into a relationship."

(HIV-positive, North Coast)

Campaign issues

An upcoming campaign produced by the AFAO/ NAPWA Education Team deals with the issues raised through recent qualitative and quantitative research regarding the development of individually tailored risk minimisation strategies for anal sex. The campaign will deal specifically with four key areas:

- "strategic positioning" or insertive/receptive roles for anal sex (perceptions of, and risk minimisation strategies based on, relative risk for HIV as the receptive or insertive partner with a known positive partner or one of unknown status);

- viral load (knowledge of viral load and its role in decisions around condom use);
- withdrawal*;
- assumptions about (and disclosure of) HIV status in casual sexual situations.

**The issue of withdrawal is included because of its history as a risk minimisation strategy, not because of any new research on this issue. We would argue for its inclusion because analysis of the SMASH study revealed that the majority of "withdrawers" are men who commonly also practise unprotected sex with ejaculation.⁷ So although most men who sometimes have sex without ejaculation inside are not deliberately practising withdrawal, it would seem that withdrawal would be an obvious question in relation to risk reduction around unprotected anal sex.*

The campaign is strongly supported by the key findings and recommendations of the *Touch wood...* study. This study identified the employment of individually-tailored risk minimisation strategies by positive men for anal sex and the possible effects of viral load on the notion of "infectivity" and a growing divide between HIV-positive and HIV-negative gay men in terms of their understanding of the impact of clinical markers on the experience of being HIV-positive—most significantly the sense of no longer being infectious to others, which is dramatically different from earlier in the epidemic. The study also found that HIV-positive men were much more articulate about negotiating ways of not using condoms compared to their HIV-negative counterparts.

Other campaigns of interest

A recent campaign by Terrence Higgins Trust, UK, called *Facts for Life* has also been influential in thinking about these issues, and subsequently the development of the ANET campaign. *Facts for Life* campaign fits into a "you decide" versus "we decide" approach to HIV prevention education. Although this is a political and ethical decision, it is also pragmatic in that it is based on the notion that the education and empowerment of gay men are ultimately more effective than the other options available—making choices for them, telling them what to do, or removing options.

The campaign is comprised of a series of statements about risk reduction strategies. These are:

- *It's safer to fuck than get fucked.*
- *Fuck or get fucked: the more men, the more risks.*
- *The longer and harder the fuck, the bigger the risk.*
- *Pulling out before cumming is safer.*
- *Sexually transmitted infections make HIV more of a risk.*
- *A higher viral load makes it easier to pass HIV on.*

- *Condoms are not 100% safe.*

Rather than using statements around risk minimisation strategies such as those used in the UK campaign as headings, we are proposing to use a series of questions instead—to emphasise the conditional or qualified nature of these strategies and the information on which they are based. It is important to acknowledge that there are degrees of risk but that a lower risk is not the same as no risk. Also, that per-contact estimates across a population are not necessarily helpful on any individual occasion.

¹ Grulich A, 'Testing times—HIV treatments and transmission,' *National AIDS Bulletin*, 1999, 12(4):12-13.

² Rosengarten M, *Touch wood, everything will be OK: gay men's understandings of clinical markers in sexual practice*, NCHSR, Dec 2000.

³ Van de Ven P et. al, 'Patterns in gay men's sexual practice indicate strategic positioning for risk reduction rather than unbridled sex,' NCHSR, NCHECR, AFAO, (submitted for publication).

⁴ Quinn TC et. al., 'Viral load and heterosexual transmission of human immunodeficiency virus type-1,' *New England Journal of Medicine*, March 30 2000, 342(13):921-9.

⁵ Vernazza PL et. al., 'Plasma HIV RNA suppression correlates with very low seminal HIV levels,' *AIDS* 2000; 14:117-20.

⁶ Berg R, *Travel Booklet Focus Test Report*, AFAO/NAPWA Education Team, Nov 2000.

⁷ Richters J, 'Anal intercourse without ejaculation as a safe sex strategy: Researching something that isn't there,' 12th World AIDS Conference, Geneva, Abstract no. 14313.