HIV Prevention in MSM: The Role of Social Science

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1. the socio-cultural ‘drivers’ of HIV-transmission in these populations

2. how understandings of these ‘drivers’ can be used to develop effective ‘interventions’ or prevention programs to mitigate transmission.
Know your epidemic and response

- Know the HIV rates and behaviours at the *local* level
- Appreciate the *local* macro-level political, socio-cultural and economic contexts
Know your epidemic and response

- Know the HIV rates and behaviours at the *local* level

- Appreciate the *local* macro-level political, socio-cultural and economic contexts in which the following are produced:
  - *sexual identities*
  - *sexual practice*
  - *risk practice*
“Consensual male-to-male sex certainly did and does take place in PNG. While the homosexual acts that took place during initiations may not have been a source of pleasure to many, but a duty to be endured, the same acts, carried out of one’s own volition with a person of one’s own choice had a different meaning and were considered pleasurable. .... many men regularly had sex with both women and men for pleasure ... Today, few young people ... are likely even to know about the beliefs and practices of their grandparents, ... “ (Jenkins, 1993+)

Reclaiming that understanding would be useful in helping people analyze and consider their evolving sexual cultures. It is not likely that HIV prevention ... will take place until frank and honest discussions about sexuality are conducted. (Lepani, 2002)
“Kathoey as a trans-gender homosexuality is institutionalised and readily visible in Thai life and unspoken rules govern the kathoey’s behaviour. They name themselves and are positioned by others as a ‘second type of women’. To engage in sex with them does not imply that one adopts a homosexual identity and in the traditional Thai scheme of things, a ‘real man’ generally maintains his masculinity in homosexual encounters as long as he performs the male role” (i.e. he is the insertive partner).

In the sixties in Thailand, the word ‘gay’ was introduced when it became apparent that ‘masculine’ men were selling sex to men.

(Storer, 1999)
In order to understand risk for HIV infection and to do effective prevention work requires an ethnographic and ‘insider know-how’ about the forms that homosexual activity takes and the norms that regulate its expression.
Reasons that prevention has faltered

Is it that we are:


2. ineffectively promoting efficacious HIV-prevention strategies

3. failing to address the social and cultural conditions in which sex and sexual risk are enacted?
The Problem

1. An exclusive focus on individuals, with assumptions of individual agency and control, and rationality

AND

2. A separation of ‘behaviours’ of individuals from the social, cultural or political contexts in which the sexual conduct of these same individuals is enacted
### Social Public Health: Modern Public Health

<table>
<thead>
<tr>
<th>Practice</th>
<th>Behaviour</th>
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<tr>
<td>Active interpretation and appropriation of information</td>
<td>Passive uptake of information</td>
</tr>
<tr>
<td>Bottom-up response from communities</td>
<td>Top-down response from experts, typically health care</td>
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<tr>
<td>Partnership of researchers, governments, ngos, health care professionals</td>
<td>professionals and researchers</td>
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<tr>
<td>with resourcing of all sectors</td>
<td>Little mutual engagement, and community input minimal</td>
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<tr>
<td>Behaviour</td>
<td>Practice</td>
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</tr>
<tr>
<td>Kissing</td>
<td>To show love</td>
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<tr>
<td>Mutual masturbation</td>
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<tr>
<td>Oral-genital sex</td>
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<td>Oral-anal sex</td>
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<td>Anal intercourse</td>
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<tr>
<td>Fisting</td>
<td>To reaffirm one’s gayness</td>
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<td>Range of more esoteric behaviours</td>
<td>For money/sex work</td>
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“has come about in major cities where a critical mass of HIV positive gay men have lived in close proximity over years, have formed social networks, and have developed a micro-culture of ideas and expectations that make sense in this particular context. ... It is also a micro-culture that is little represented in smaller cities where the sense of a “poz” world cannot be sustained. It also borrows ... some of the major planks of neoliberal ideology ... As such, it combines together notions of informed consent, contractual interaction, free market choice, and responsibility that create a platform for constructing unprotected sex as a “responsible” choice among adult men.” Adam, 2005.
Sexual Practice

Practices are socially produced; they are behaviours that are organized and patterned by culture and organized with reference to normative understandings or discourses: they have meaning (Kippax, 2003).

The most powerful influences on human sexuality are social norms – morals, taboos, laws, beliefs – that regulate and govern its expression. The scale of the regional diversity in sexual practice is matched only by the range of cultural constraints on practice (Wellings et al., 2006).
HIV-prevention information is not passively imbibed by individuals but must be actively taken up (appropriated) through talk and collective action within a given social context in order to acquire meaning and become part of everyday life. For example, condom use becomes normative within certain communities – one has to explain why one is not using a condom, not vice versa.
Risk Reduction Strategies

- Condom use
- Negotiated safety
- Poz-poz sex
- Strategic positioning
- Serosorting/guessing
- Reliance on undetectable viral load
- nPEP
- Treatment of STIs
The strategies, including condom use, came from gay men – from within community.

Gay men observed and interpreted and resisted the strategies imposed from the outside, e.g. monogamy and abstinence. The strategies, the effective and sustainable strategies, came from within – from the bottom-up not the top-down.
Within the social public health model, success (and failure) lies in the ability of policy makers and researchers to enter the life worlds of members of the communities or populations at risk and understand the world from their point of view. It lies in policy makers’ and researchers’ ability to build on the understanding and practices of the communities at risk and to harness their collective energies and attempts to respond – in this case - to the risk of HIV.

What is needed is an intelligent engagement from each side.
‘Social’ Public Health

Focus on
  - Practice

informed by
  - Active interpretation and appropriation of information

by
  - Communities

informed and supported by
  - Involvement of researchers, governments, ngos, health care professionals in partnership
‘Modern’ Public Health: Testing and Counselling

The clinic does **not** provide the context for effective prevention.

1. People are positioned as patients, passive recipients of information and advice. Such top-down educating is disempowering and pays little if any attention to the ways in which the VCT messages are interpreted and understood by those who receive the message.

2. Prevention in the clinic is individualistic (at its best it talks to couples) and hence it makes little if any impact on prevailing normative understandings of sex and risk. Knowledge is privatized.

3. Prevention in the clinic has a tendency to pathologise. It reinforces notions of individual responsibility and may feed blame and shame, and more generally, stigma and discrimination.
Example from South Africa

During the course of testing day, some 200 Ithangans drifted to and from the school. Most had come not to test but to watch. Their curiosity was profoundly ungenerous: they had come to see who was HIV-positive. It was believed that it was not hard to tell – to know who was positive you just had to stand and observe. You looked for how long the people stay. You see there is counselling before and after the test. The counselling before the test is the same for everyone, a few minutes. But the counselling after the test – for some it lasts two minutes for others it is a long long time. And then you know. By the end of the day the whole village knew who had tested HIV-positive.
Reasons that prevention has faltered

Is it that we are:

1. promoting ineffective HIV-prevention strategies? (Potts, Halperin, et al.)
2. ineffectively promoting effective HIV-prevention strategies
3. failing to address the social and cultural conditions in which sex and sexual risk are enacted?
What we have to do

- address the social and cultural conditions in which sex and sexual risk are enacted
- in partnership with community develop effective HIV-prevention strategies that are appropriate to the local socio-cultural, political and economic conditions – and these are likely to come from community
- use effective means of promoting those strategies – including resourcing communities to develop and run their own education campaigns
While not opposed to the use of top-down shifts in policy and regulation as a means of encouraging risk reduction, the social transformation theorists suggest that the most successful strategies for prevention are likely to be those that are sensitive to the practices and desires of particular communities.

We need to keep abreast of constantly shifting identities, practices, subcultures, responses to technologies … while insisting on the social and cultural dimensions of these shifts.
How Promoted: Prevention Interventions

- Social marketing – both general population and targeted
- Community-based and peer education and health promotion
- Education through schools/ work force/ sex worker industry…
- Counselling and testing (VCT or provider-initiated)
- Clinical interventions – such as STI treatment or treatment of PLWHA
Efficacy of an intervention is “… the improvement in health outcome achieved in a research setting, in expert hands, under ideal circumstances”

Effectiveness of an intervention is “…the impact an intervention achieves in the real world, under resource constraints, in entire populations, or in specified subgroups of a population. It is the improvement in a health outcome…”

Illustration of the importance of local cultural understandings:

- “[evidence] suggests two key ways in which traditional Xhosa circumcision has changed… the role which circumcision schools once played in the sexual socialisation of young men and the emergence of the idea that initiation gives men the unlimited and unquestionable right to access to sex rather than marking the point at which sexual responsibility and restraint is introduced…” (Vincent, *Culture Health & Sexuality*. June 2008)
Conclusions

- One size does not fit all and comprehensive HIV prevention packages are needed that are grounded in understandings of local cultures.

- Attend to issues related to stigma and discrimination, including gender violence.

- Biomedical and social researchers must work together.