Sustaining Safer Sex Behavior in the Era of HIV/AIDS

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ABSTRACT

Although rates of condom use with new sexual partners has increased significantly over the life of the AIDS epidemic, sustained condom use within longer-term relationships remains low. This article: (1) examines societal patterns of sexual behavior within the context of public health messages about sexuality; (2) reflects on the intersection of sexual behavior, sexual health, and sexual values; and (3) makes recommendations for sustained safer sex behavior as the fourth decade of the HIV/AIDS epidemic approaches, including the importance of developing HIV risk reduction messages that are responsive to: (1) their predominant sexual and safer sex behavioral patterns; (2) the societal gender roles, norms, and scripts that guide sexual interactions; and (3) developmental and cultural influences on sexual behavior.

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Background

The World Health Organization (WHO, 2011) estimates that over 34 million lived with HIV globally at the end of 2010. Most people infected with HIV reside in low-income and middle-income countries. The 15-24 year age group accounts for about 40% of new HIV infections annually (WHO, 2011). This paper examines societal patterns of sexual behavior within the context of public health messages about sexual behavior; reflects on the intersection of sexual behavior, sexual health, and sexual values; and offers recommendations for sustained safer sex behavior as the fourth decade of the HIV/AIDS approaches.

History of Public Health Messages about Safer Sex

A previous article examined public health messages in the United States pertinent to HIV/AIDS (Seal & Ehrhardt, 2004). Overall, four primary waves of messages emerged: (1) Don't have sex with gay men or injection drug users (IDU); don't be gay or an IDU; (2) Be abstinent; be monogamous; always use a condom (ABC model); (3) Know your partner; avoid risky partners; and (4) Negotiate safety and harm reduction.

More recently in the United States there has been an initiative toward a comprehensive Seek, Test, Treat, and Retain (STTR) strategy to early identification of new HIV infections and linkage to treatment. Although this analysis has been based on public health messages in the United States, arguably, the essential elements of these messages are present worldwide.

As stated in a previous article (Seal & Ehrhardt, 2004), these public health messages, though well intended, perhaps have done as much harm as good for HIV prevention efforts over time. Some early messages stigmatized entire

population groups (e.g., gay men, IDUs) regardless of individual risk behavior, and at the same time, gave other groups (e.g., heterosexuals) a false sense of security. Although popular among some public health practitioners, the ABC model ignored epidemiological studies of sexual behavior indicating that most adults do not choose lifelong monogamy (i.e., restricting themselves to just one sexual partner), do not use condoms consistently, especially in primary relationships, and for the majority of people, have sex before marriage.

Later messages failed to acknowledge that HIV and other sexually transmitted infections (STIs) often lack overt symptoms, that many people do not accurately know and/or disclose their HIV serostatus, and that people are generally poor judges of a potential partner's sexual risk due to use of implicit personality theories and denial - "my partner is *not* risky" as "I know him/her." Furthermore, the ambiguous association between knowledge about a partner's sexual history and actual risk or preventive behavior has been well documented (Cline et al. 1992; Mays et al. 1993; Seal, 1997). "Get to know your partner" or "negotiated safety" messages may be more appropriate for short-term or developing relationships than for long-term ones. That is, they may better define condom use under specific circumstances rather than all the time. Within longer relationships, however, people have questioned whether these messages result in negotiated safety or negotiated harm given the many barriers to definitively learning a partner's serostatus and/or maintaining negotiated agreements over time (Elford et al. 1999; Hoff & Beougher, 2010; Hoff et al. 2010; Mitchell et al. 2010; Mitchell et al. in press).

The more recent STTR prevention approach also makes many assumptions, including: (1) people have the motivation and capacity to be tested, (2) they have access to testing if motivated, (3) people who receive HIV-positive test results can be linked to affordable treatment, and (4) people identified as HIV-positive linked to treatment can be retained over time and remain medication adherent. The STTR approach, which often frames HIV as a manageable chronic disease, given the efficacy of current antiretroviral therapy, also has led HIV-negative individuals to minimize the health consequences of HIV infection and increased willingness to engage in risky sexual behavior (Kippax & Race, 2003). In addition, the long-term effects of sustained antiretroviral therapy on long-term health outcomes and age of mortality are still an emerging area of study as people who are HIV-positive live longer healthier lives.

Looking back, one can posit that HIV-prevention public health messages have often neglected to take into consideration the realities of human sexuality and the many ways people re-invent public health messages to generate a sense of safety from their own sexual behavior and that of their partners. The context of sexual behavior and safer sex are not value-free and these behaviors cannot be reduced to monolithic acts that happen in isolation of relational context. Rather, sexual transmission of HIV occurs primarily in four core relational contexts: (1) in steady and affectionate "monogamous" relationships; (2) in casual relationships or "one-night stands," (3) in commercial or sex worker relationships, and (4) in exploitive relationships. Further, HIV infection disproportionately impacts people characterized by impoverishment, disenfranchisement, and minority status. In most cultures, people at highest risk for HIV infection are often members of society who experience the highest marginalization, oppression, and stigmatization (UNAIDS, 2009; 2010).

Although a long-term monogamous relationship is still seen as the ideal safer sex compromise between total abstinence and the desire for frequent sexual intimacy among prevention specialists, this behavior is not enough to protect many people against HIV infection risk. Indeed, globally most women living with HIV/AIDS were in-

fected by a primary male partner (WHO, 2011). Moreover, an increasing percentage of men who have sex with men are also infected within primary relationships (Sullivan et al. 2009). Risk of HIV transmission from an intimate partner increases as economic power, relational power, and other inequalities increase (UNAIDS, 2010).

Finally, in moving forward into the fourth generation of the HIV epidemic, one can pose the following question: *Should the primary prevention goal be to change normative behavior fundamentally, as past messages have attempted to do, or to make fundamental normative behavior safer?* Implicit in this question is whether a prevention message is right (e.g., "be monogamous") just because most people do it or say people should do it. This question also spotlights abstinence-based versus harm-reduction approaches to HIV prevention. Consider the example of extradyadic sexual behavior, which is discouraged in most HIV prevention public health messages. As has been challenged previously (Seal & Ehrhardt, 2003; 2004; Seal, Wagner, et al. 2000): (1) do we aim to discourage a behavior which is normative within some cultural groups and can serve an important social-sexual function; or (2) do we accept the behavior in our prevention efforts, but aim to promote consistent condom use with extradyadic partners to protect the primary relationship?

Examples of Socio-ecological Approaches to Studying Sexual Behavior

Prevention specialists view a socio-ecological approach to health behavior as being a productive change strategy (McLeroy et al. 1988). Furthermore, sexuality and sexual behavior norms must be a starting point for sexual health promotion not an afterthought. Public health messages must take into consideration the core components of both intimate and non-intimate sexual relationships, including the human desire for sex, love, passion, and intimacy. These core components encompass salient patterns of sexually and emotionally intimate behavior, including multiple lifetime serial monogamy; incidence of concordant sexual partnerships and same-sex sexual behavior; penetrative intercourse as the endpoint of the male sexual script; inconsistent patterns of condom use especially within steady relationships; competing desires for emotional intimacy and love versus sexual intimacy, desire, and pleasure; the role of secondary sexual partners; and contraception versus disease prevention goals. Prevention efforts must be directed both to men and to women at multiple levels and address all types of sexual partnerships, not just steady heterosexual relationships.

Prevention should build upon cultural strengths and natural tendencies and use natural behavioral tendencies within culture as enablers rather than as deterrents of sexual safety (De La Cancela, 1989; Seal, Wagner et al., 2000). At an interpersonal level, efforts must be directed toward recognition of men's and women's respective roles in and responsibility for disease prevention. At a sociocultural level, efforts must be directed toward men and women that attempt to change fundamental norms and beliefs about masculinity and femininity that often underlie sexual risk behavior. Yet, as prevention efforts seek to promote cultural change, we must give attention to developing new cultural scripts that are feasible and acceptable so as to avoid role strain caused by changing roles, scripts, and values. Prevention efforts also must account for the complex relationship among sexual identity, desire, attraction and behavior.

At an institutional and/or governmental level, social, moral, and legal policies that contribute to inequalities related to gender and sexual identity that increase HIV vulnerability must be changed so as to promote gender rights, human sexual rights, economic independence, control of self and destiny, and freedom of sexual expression. There is a need

for early and comprehensive sexuality education that emphasizes positive sexuality rather than sexual pathology.

The timing of HIV prevention efforts also may be critical. That is, there may be "windows of opportunity" during which safer sex promotion may be most effective. At an interpersonal level, condom use may be most likely during the development of new relationships or during relational transitions or crises (e.g., pregnancy, STI infection). At a sociocultural level, educational programs that shape healthy social and sexual norms among youth before they crystallize into habitual patterns of sexuality and sexual behavior may be fruitful. At a governmental and institutional level, periods of sociopolitical crisis or transformation also may offer windows of opportunity to change societal norms around sexuality that increase people's risk for HIV transmission and infection.

We also need sustained sexuality education and safer sex promotion efforts that anticipate disease breakouts and address these breakouts proactively rather than as crisis management initiatives. All too often over the first 30 years of the HIV epidemic, prevention efforts have focused on emerging disease epidemics rather than proactively evaluating precipitating contexts that often precede disease outbreaks (e.g., rises in poverty and societal disparities, rapidly growing STI and hepatitis outbreaks, opening of borders to Western influences and tourism, increases in societal sex work and injection drug use). Once the HIV epidemic has emerged, it is often too late for effective prevention strategies to make an epidemiological impact.

In closing, the following quote captures the difficulty of HIV prevention messages that ignore human desire for sex, love, passion, and intimacy (Seal, Kelly et al., 2000):

> *This man was beautiful. After the fourth time we had sex in 14 hours, we were laying there and he said he had something to tell me. I was just thinking please don't tell me he's going to say that he has HIV or something. And he just kind of turned to me and said I should have told you earlier, but I'm positive. I was like oh my God, but I didn't freak out because I knew what I had done. I had chosen to let him fuck me without a condom. What was I going to do? Take out a knife and stab him? So I rolled over and went to sleep. The next morning I woke up and saw he had a hard on and made him fuck me again. The sex was just that good.*

References

Cline, R.J.W. et al. (1992). Talk among sexual partners about AIDS: Risk reduction or risk enhancement. *Health Communication*, *4*, 39-56.

De La Cancela, V. (1989). Minority AIDS prevention: moving beyond cultural perspectives towards sociopolitical empowerment. *AIDS Education and Prevention*, *1*(2), 141-153.

Elford, J., et al. (1999). Sexual risk behaviour among gay men in a relationship. *AIDS*, *13*, 1407-1411.

Hoff, C.C., & Beougher, S.C (2010). Sexual agreements among gay male couples. *Archives of Sex Behavior*, 39, 774–787.

Hoff, C.C. et al. (2010). Serostatus differences and agreements about sex with outside partners among gay male couples: differences by agreement type and couple serostatus. *AIDS Care*, *22*, 827–835.

Kippax, S., & Race, K. (2003). Sustaining safe practice: twenty years on. *Social Science and Medicine*, *57*, 1-12.

Mays, V.M., & Cochran, S.D. (1993). Ethnic and gender differences in beliefs about sex partner questioning to reduce HIV risk. *Journal of Adolescence Research*, *8*, 77-88.

McLeroy, K.R. et al. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly*, 15(4), 351–377.

Mitchell, J.W. et al. (2010). Relationship factors associated with HIV risk among a sample of gay male

couples. *AIDS and Behavior*, *16*, 404-411.

Mitchell, J.W. et al. (in press). Understanding the agreements and behaviors of men who have sex with men who are dating or married to women: unexpected implications for a universal HIV/STI testing Protocol. *International Public Health Journal.*

Seal, D.W. (1997). Inter-partner concordance of self-reported sexual behavior among college dating couples. *The Journal of Sex Research*, *34*, 39-55.

Seal, D.W., & Ehrhardt, A.A. (2003). Masculinity and urban men: perceived scripts for courtship, romantic, and sexual interactions with women. *Culture, Health, and Sexuality*, *5*(4), 295-319.

Seal, D.W., & Ehrhardt, A.A. (2004). HIV prevention-related sexual health promotion for heterosexual men in the United States: pitfalls and recommendations. *Archives of Sexual Behavior*, *33*(3), 211-222.

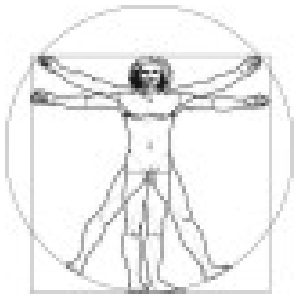
Seal, D.W., Kelly, J.A. et al. (2000). HIV prevention with young men who have sex with men: what young men themselves say is needed. *AIDS Care*, *12*(1), 5-26.

Seal, D.W., Wagner, L.I. et al. (2000). Sex, intimacy, and HIV: an ethnographic study of a Puerto Rican social group in New York City. *Journal of Psychology and Human Sexuality*, *11*(4), 51-92.

UNAIDS (2009). Agenda for accelerated country action for women, girls, gender equality, and HIV. Retrieved March 10, 2012 from http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/20100226_jc1794_agenda_for_accelerated_country_action_en.pdf.

UNAIDS (2010). Non-discrimination in HIV responses. Retrieved March 10, 2012 from http://www.unaids.org/en/media/unaids/contentassets/documents/priorities/20100526_non_discrimination_in_hiv_en.pdf.

World Health Organization (2011). Key facts on global HIV epidemic and progress in 2010. Retrieved February 7, 2012 from http://www.who.int/hiv/pub/progress_report2011/global_facts/en/.



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