Safesex is a gay, grass-roots invention. In fact, just about every behavioral technique used in the U.S. to stop or slow the spread of HIV was invented and first practiced by gay men. These techniques were considered risky by the public health establishment when they were first promoted. It was only later, as their effectiveness was gradually revealed, that public health authorities accepted them and turned them into public health policy. Now, a recent trend in HIV prevention among gay men, called serosorting, is getting a lot of attention. But how effective is serosorting?

Serosorting is the practice of selecting partners according to whether they are HIV positive or HIV negative, having sex only with someone of the same HIV status, or always using condoms only with people of a different HIV status. It implies having unprotected anal intercourse when both partners are already HIV positive, or when both are HIV negative.

Other behavioral strategies that aim to prevent HIV infection without using condoms fall within the larger category of “seroadaptation”. These include “strategic positioning”, in which the insertive (top) and receptive (bottom) sexual roles are chosen according to HIV status, relative risk, or viral load, with the uninfected partner typically taking the insertive role. Another seroadaptive behavior is the use of viral load as a basis for decision-making. When a person with HIV has an undetectable viral load, some gay men feel it is safe to have sex with an uninfected partner without using condoms, especially if the man with HIV is the bottom. But while an undetectable viral load lowers the risk of HIV transmission, it does not eliminate it.

What serosorting and other seroadaptive behaviors have in common is the search for ways to have unprotected or condomless sex while still avoiding HIV
To the Editor:

I’d like to thank you for the information you put in Achieve. I’ve been trying to learn more and more ways to prevent HIV/AIDS and STIs because in the 1990s I lost my aunt to the infections you get when you have AIDS. By the time she got tested, it was too late. That’s what the doctors said.

I’m 21 now and HIV negative. I’m also in the prison system. I was in the PACE program at Marcy Correctional Facility and that’s where I got Achieve. I read it and liked what I read. I just wish my aunt could have read it.

But now I try my best to encourage people all over to have safer sex, be careful, and get tested at least once a month.

I’d like to learn more and keep reading your magazine. I’d highly appreciate it if I could get a copy of it whenever a new one comes out.

Thank you so much for everything you are doing.

Timothy

Achieve would love to hear from you!
Please send your comments to: Letters to the Editor, Achieve, 230 W. 38th St., 17th floor, New York, NY 10018, or email them to: achieve@acria.org
infection. Since all these practices feature sex without condoms, public health officials and HIV advocates are concerned that this new “grass-roots” method of HIV-prevention may turn out to be risky and lead to an increase of new infections among gay men. Are they right?

**When Negative Isn’t Negative**

There are real issues with risk-reduction practices that try to do away with condoms. To be effective, they need to be used carefully, intelligently, consistently, and with awareness of the larger context. Serosorting is certainly safer for HIV-positive men than it is for HIV-negative men. First, while people with HIV can be superinfected with a different strain of HIV, experts are divided on how common this is and its consequences. Second, men who have tested positive know their HIV status – someone who says he has HIV is probably not lying. Finally, sex between HIV-positive men cannot transmit HIV to uninfected men – a lesser impact on public health.

For HIV-negative men, however, strategic positioning, partner serosorting, and unprotected receptive anal sex with an HIV-positive partner who has an undetectable viral load are all subject to misuse. In 2008, 63% of sexually active HIV-positive men in U.S. urban areas between the ages of 18 and 29 were unaware they had HIV, according to the latest figures from the CDC’s National HIV Behavioral Surveillance report. This is quite worrying, because a person who has been recently infected is extremely infectious. In fact, approximately half of new sexually acquired HIV infections in the U.S. are transmitted by the 21% of HIV-positive people who are unaware of their HIV status. This means that having unprotected sex with a guy who says, even believes, that he is uninfected may be very risky for someone who is HIV negative.

One study that ran from 2001 to 2007 observed serosorting trends among HIV-positive and negative gay men who received services from a clinic in Seattle, Washington. The study showed that the practice of serosorting increased over the six years, especially among HIV-positive gay men. Of those men who became HIV positive over the course of the study, 32% were gay men who practiced serosorting. Perhaps those men had taken other, greater risks in their sexual practices. Still, those findings suggest that serosorting does not eliminate the risk of contracting HIV. The level of protection that comes from serosorting is uncertain. But what is certain is that there are many ways serosorting by HIV-negative men can fail to provide protection from HIV.

Recent studies have shown that HIV treatment can substantially lower the rate of transmission from a positive but treated partner to a negative partner, especially when the positive partner has an undetectable viral load. But this belief may have particularly dangerous results for gay men. First, new research suggests that only 19% of HIV-positive people in the U.S. actually have an undetectable viral load. The CDC has a more optimistic estimate of 28%, based on more recent data and a different method of calculation, but it still seems reasonable to assume that only about a quarter of all Americans currently living with HIV have their viral load down to an undetectable level. Second, viral load fluctuates significantly, even in people who succeed in getting it down to undetectable levels. Third, even if the virus cannot be detected in your blood, it may be present in your semen (which is not tested).

A recent study of 101 HIV-positive men who have sex with men found this to be true. The Fenway Institute in Boston discovered that roughly a quarter of the men with undetectable HIV in their blood had detectable HIV in their semen. The study also showed, however, that men with unde-
the heterosexual couples was vaginal sex. Unfortunately, the risk of HIV transmission through anal sex is much higher than through vaginal sex. So gay men should not throw out their condoms because of the results of this study. More research is needed to understand if an undetectable viral load in the blood reduces HIV transmission in people who practice anal sex.

Proiling
There are also other unwelcome consequences of trying to move beyond condom use while still trying to avoid HIV. The technique of partner sorting rather than condom use leads some gay men to practice racial sorting, because the prevalence of HIV is known to be higher among black men and Latinos than among white men. Sorting partners by age is another misguided attempt to stay HIV negative without using condoms. These techniques only serve to continue misinformation about contracting HIV, while promoting racist and ageist behavior.

Although there is much to be concerned about regarding sero-sorting, we should also remember that the risk-reduction practices that are currently approved as safe were not considered safe when they were first invented. What is now called safer sex (using condoms) is a case in point. Nowadays, safer sex is routinely contrasted with risk-taking, barebacking, and other supposedly irresponsible forms of unprotected sex. The terms “safe” and “unsafe” sex are pitted against each other as polar opposites. But the use of condoms for anal sex was “possibly unsafe.” The use of condoms was a gamble by gay men that involved a willingness to accept a reasonable but unknown risk, in order both to defend their lives from a lethal epidemic and to preserve their erotic pleasures.

The use of condoms for anal intercourse, the practice of oral sex without ejaculation, and other kinds of risk-reduction techniques have proven practical and effective in slowing or reducing the spread of HIV, despite having once been considered risky. This is important because it is unreasonable and impractical to expect people to take no risks at all. A policy of total risk elimination can be difficult to sustain over a person’s entire lifetime. Too strict an insistence on eliminating all risk can backfire, leading to periodic and highly risky lapses, which can be quite dangerous. The safety of any specific prevention technique should be measured not just by how well it protects people from infection in any particular act of sex, but how well it protects them over the course of a lifetime.

Changing Behavior
Once an infectious disease has taken hold in a population, it is very difficult to get rid of it by purely behavioral means. It’s all very well to ask people to alter their behavior, but no one expects behavioral interventions to be completely effective. During a flu outbreak, we may try to wash our hands and cough into our sleeves, but we don’t think it’s up to us as individuals to stop the epidemic by altering our behavior. We place our hopes in a vaccine. Until there is a vaccine or a cure for AIDS, behavioral interventions remain our best weapon (though we are gradually finding biomedical options, too – see page 13). Meanwhile, some of us are simply going to get sick. That is not necessarily our fault; there’s an epidemic out there!

Partner sorting leads some gay men to practice racial sorting, because the prevalence of HIV is higher among black men and Latinos than among white men. Sorting by age is another misguided attempt to stay negative without condoms.

It is clear why the safer sex techniques that gay men invented could not have been embraced at the outset by public health authorities; they were not absolutely safe. They involved risks, sometimes quite significant risks, depending on how skillfully they were practiced, how intelligently and consistently they were put into operation, and how the larger social context of their use evolved. Risk-reduction practices have to be monitored so that they do not lead to risk increase.

What these historical examples imply is that “safety” and “risk” are not black-and-white categories. A lot of what passes today for safer sex is the result of earlier spontaneous improvisation by gay men with varying degrees of risk. This collective effort continues, as gay men experiment with their own bodies to find compromises and practical solutions that may prevent the spread of HIV while not destroying their unique cultures of pleasure.
Negotiated Safety

Serosorting is the latest of these attempts. But when HIV-negative men use it instead of condoms, especially with casual partners or with those whose HIV status is unknown (which is often what “HIV-negative” really means), they are taking significant risks – both for themselves and for the gay community as a whole.

“Negotiated safety” is a concept that might be called “serosorting plus”. It involves an agreement between two HIV-negative partners in a stable relationship, who after being together for a while, repeatedly testing negative, and talking through the issue, decide to give up using condoms with each other. They also agree either to be monogamous or always to have safer sex with other partners. Some agreements include a decision not to have anal sex with casual partners.

“Negotiated safety” was coined in 1993 by the Australian researcher Susan Kippax, who discovered this prevention technique by studying how some HIV-negative gay male couples actually behaved. She argued that not all condomless sex should be considered unsafe – it depended on the context. The same thing is true of serosorting in general. In the case of negotiated safety, Kippax found that couples who had an agreement not to have anal sex with casual partners turned out to have less chance of being infected.

The effectiveness of negotiated safety as a prevention technique can vary widely. To make it work, it should involve:

- Repeated testing of both partners
- A waiting period before taking off the condoms
- An agreement to be monogamous, or to avoid risky sex with others and always to use condoms when having anal sex with others
- An agreement to inform each other immediately if either partner slips up, has risky sex with someone else, or breaks the agreement in some other way, and to start using condoms again until repeated HIV tests are negative

Without the final element, an agreement could be very risky, since few of us would likely admit to our primary partners that we had had unsafe sex with someone else if we thought that such an admission would mean the end of our primary relationship.

The same thing applies to monogamy as a prevention technique. After all, being in a monogamous relationship with a partner who is unfaithful but afraid to admit it does not afford any protection.

That is one of the reasons why love itself can be a risk factor for HIV infection.

Does negotiated safety really work? In 2005, a U.S. survey of 340 HIV-negative gay men in San Francisco found that 38 of them were in long-term seroconcordant HIV-negative relationships and had some form of negotiated safety. Of those men, 11 had broken their own rules in the preceding three months.

Three-quarters of the men also had a rule that they must tell their primary partners if they had broken their agreement. This did seem to help – only 18% of those with an “always tell” rule had strayed outside their agreement, while the 60% of those who had no such rule had in fact broken their agreement.

Finding ways to push safer sex beyond condom use and exploring ways to have safer sex without condoms could prevent the “condom fatigue” that is now so common in the gay community. And it should also remind us that the condom is our friend, insofar as using it gives us more sexual freedom than we can safely have without it. It also sends the message that even though HIV prevalence is higher in the gay community than among heterosexuals, it is still possible for both HIV-positive and HIV-negative gay male couples to enjoy the intimacy of condom-free sex, as their straight counterparts routinely do.

Conclusion

Gay men have a bad rap about sexual risk-taking. But we shouldn’t lose sight of the fact that the majority of gay men in the U.S. are not HIV positive, that they consistently practice safer sex, and that most will likely remain uninfected. Until there is a vaccine or a cure for AIDS, behavioral interventions remain our best weapon. As we wait for better information on the effectiveness of serosorting and other grass-roots HIV prevention techniques, efforts should be made to remind gay men that we were the first to adopt the condom as a weapon against HIV – and as our ticket to an expansive and nondiscriminatory sexual culture.

David Halperin is the W. H. Auden Distinguished University Professor of the History and Theory of Sexuality at the University of Michigan. Robert Valadéz is a policy analyst at GMHC.
Today, over 30 states in the U.S. make it a crime not to disclose one's HIV-positive status in certain sexual situations. In some of these states, a conviction will also place that person on a sex offender registry — sometimes for life. This requires people to disclose their status as sex offenders every time they look for housing or employment or move into a new neighborhood. Legal scholar J.J. Prescott once noted that requiring people to disclose their sex offender status for the rest of their lives feels a lot like prison, and may actually make them more secretive than open.

Despite what you may have heard, laws requiring HIV disclosure during a sexual encounter are not enacted with the goals of sharing facts and promoting safer sex. They are designed to confuse facts and make it almost impossible that any sex act will happen at all, be it safe, unsafe, or unsure. Legally requiring HIV disclosure in laws ignores the facts about actual risks of transmission. And because it is almost impossible to become or stay friends with someone who has rejected you, these laws also ruin chances for some very creative kinds of relationships that might happen after sex, or even after just talking about sex.

One Man's Story
I once had an exchange of emails with a guy in Los Angeles whose online profile looked interesting. The conversation was going well, and we were about to make dinner plans to see if we would also click in person. Prior to this, we talked about what we were “into”, as the phrase goes. We agreed that there would be no unsafe stuff and then made a list of fun things to do if we hit it off. This sort of “letter to Santa” may sound like the typical gay, cut-to-the-chase attitude that so many straight people pretend to find disgusting (but secretly want). In my case, though, coming up with a plan of action is also a way to make sure that I will have no legal responsibility to disclose my HIV status if I don’t want to. Or, if I do want to disclose, to increase the chances that the other guy will still want to play.

This time, though, I was hoping for something more than just a hook-up. Maybe a little dating and hanging out, too. And I didn’t want to risk any future possibilities by seeming less than honest at the start. This is one of the cruelest things about HIV disclosure. Either you say something and run the risk of killing a sexual encounter, or you keep quiet and just get together with the guy, probably killing the chances of turning a one-time thing into a more lasting relationship or even a friendship.

Anyway, this guy didn’t sound all that great, so I told myself I wouldn’t be losing that much if I told him that I had HIV. Plus, he told me he had attended medical school. So before we even met, I told him. I reminded him that we had decided to be safe and just to be, well, safe, I explained what having an undetectable viral load means in terms of risk. His reply was, “Hey David, thanks for your honesty. Unfortunately, I have to say that I would be uncomfortable playing. I know that safe play would most likely prevent anything. However, being a healthcare professional, I

Adventures in Online Cruising

by David Caron
know that anything is possible. I apologize for being very shallow about this, but it’s not something I am willing to risk. I hope you understand.”

In all fairness, it is true that no matter what you list in your “letter to Santa” you can always end up with a surprise in your stocking. I found myself so hurt by this guy’s rejection! It felt like intense discrimination against me, my body, my life, and my… everything! It killed my cruising (and more) for a long and painful time. Although he didn’t use the phrase, his need to be on the safe side actually separated us into two sides, placing himself on the safe side and me on the unsafe, automatically.

His reply was, “I would be uncomfortable playing. I know that safe play would most likely prevent anything. However, being a healthcare professional, it’s not something I am willing to risk.”

**Understanding?**

Especially irritating is that people who reject you on a completely irrational basis will often ask for your understanding. Clearly, they use the word to mean something like compassion or sympathy, as if they were the victims of your intolerance. But they hope nonetheless to capitalize on the rational sense of the term, and apply its legitimatizing power beyond the realm of reason. To describe an emotion as “understandable” seeks to make it reasonable. In the end, I replied “No, I can’t say that I understand, but I’m getting used to people’s unfounded fears.” Even more passively-aggressively, I added, “If anything, I appreciate the fact that you bothered to reply. Most people don’t.” Talk about a back-handed compliment. And because I really couldn’t let him off so easily, I finished with the rather devious send-off, “Good luck trusting future partners who tell you they’re not HIV positive.”

Most people who claim that they will not have sex with HIV-positive people have actually done so. This is because some people choose not to, or are afraid to, disclose their status. Or, as is the case with many people who are HIV positive, they just don’t know. About 21% of people with HIV in the U.S. are unaware of their infection, and a 2006 study estimated that 54% of all new infections come from that group.

Often, the topic isn’t discussed at all. For example, in online ads the shorthand DDF, for “drug and disease-free”, may be used to show that someone claims to be HIV negative and expects others to be as well. More and more online profiles now include the date of the person’s last negative test results. It would be interesting to ask if the date refers to the day the blood was drawn or when they received the results. I guess they have all decided to trust each other to know their status and tell the truth.

**HIV- UB2**

The practice of announcing and dating negative test results may have started because it makes it seem as if the claim can be backed up by evidence. Yet it is just as pointless as claiming to be DDF. We know that HIV transmission is most likely when the viral load is especially high. This happens twice in the entire course of the disease – when one is nearing death (and unlikely to be sexually active) and immediately after infection (when one is sexually active) and when the commonly used test (which measures antibodies to the virus rather than the virus itself) will come out negative. So when people tell you that they are HIV negative as of this morning, it could just as well mean that they are in fact highly infectious.

Simply said, unless someone has tested negative three months after the last sexual activity and has not had sex since the test, you just can’t be absolutely sure. Of course,
people can always decide to stick to safer sexual activities. But in that case, why would they need to know their partner’s HIV status in the first place?

So why do people choose to believe someone who claims to be HIV negative when such belief is unsure at best and foolish at worst? That’s like asking why people start smoking or why some text while driving. I haven’t done the research, but my feeling is that “DDF” and “negative as of...” are just ways to prevent any discussion of HIV because the topic is such a killjoy. This has nothing to do with lowering risk but is really meant to remove the very idea of risk from people’s minds during sex.

HIV disclosure, whether required by law or expected as an ethical matter, is part of a system of prevention and depends on the idea of individual responsibility. But these conversations are often based on mistaken beliefs about risk. So why are they still expected? Do people really believe in the power of this system?

I once called a guy on what seemed to me an odd contradiction in his online profile. To the question of whether he practiced safer sex (a far more useful bit of information than HIV status) he had selected “Always”. Yet on the list of “Things I’m into” he included “Barebacking”. This is in fact a very common occurrence. When I asked what he meant, he explained, “When the guy is 100% percent sure he’s clean I don’t use condoms, but otherwise I always do.” Any sign of irritation or bafflement on my part could have jeopardized the hook-up so I kept quiet. After asking more questions, I came to the conclusion that certain people do not understand barebacking to be inherently risky. To them, it all depends on the other guy’s status. That seems logical, but is the internet in general, and cruising sites in particular, a place to turn to when looking for the truth? The reality is that a negative status is often far less certain than a positive one.

But who really cares if what people write in their online profiles sounds dumb or even AIDS-phobic as long as we all get laid, right? Should we take such ignorance and rudeness as outright rejections? Maybe not. What these online cruisers really offer to other cruisers, whether they mean to or not, is the possibility to read written mentions of HIV as unwritten invitations not to care about it. But to say in an online profile that you don’t really care about a partner’s HIV status may drive some potential playmates away because they will assume you’re HIV positive yourself and are attracting others for the same reason. To say you are HIV negative or to request an HIV-negative partner when you really don’t believe what a potential hook-up says could mean that you’re using the system to fight the structures that oppress us.

**Conclusion**

In summary, there are five basic reasons that questioning partners about HIV status before casual sex is not the right approach:

1. **The information is useless.** A stranger has little incentive to be honest with another stranger, and since no emotional bond exists, there may be no concern for the other’s well-being.

2. **They may not know they have HIV.** Even if the person is concerned for your safety, over half of all new infections may come from people who do not know they have HIV. And even if they claim a recent negative test, they could be in the process of seroconverting, in which case their HIV viral load would be extremely high.

3. **It could lead to greater risk.** Once you accept the assumption that someone is negative, you may do things that you feel are unsafe. Particularly in the heat of passion, very risky behaviors like unprotected anal sex may be practiced because the partners believe they are both negative. This is
What these online cruisers really offer to other cruisers, whether they mean to or not, is the possibility to read written mentions of HIV as unwritten invitations not to care about it.

a particular problem in new relationships, in which the condoms often come off quickly because both partners think they are negative. Many people have acquired HIV in this scenario, often because the positive partner did not know he had HIV.

4. **It really shouldn’t matter.** It’s actually quite easy to prevent HIV transmission during sex, by taking some simple precautions (such as knowing how to use a condom correctly or avoiding high-risk behaviors like anal sex). If the person with HIV has an undetectable viral load and uses a condom, the chance of transmission is nonexistent.

5. **It encourages nondisclosure.** People with HIV learn very quickly that disclosing will limit their chances of casual sex and will often lead to painful rejection. Every time negative people reject positive people, they train them not to disclose.

To return to the doctor from L.A., he never bothered to ask my status and was willing to play safely with someone without any mention of HIV. Yet he couldn’t bring himself to do it once he knew. In the end, it wasn’t the possibility of HIV itself that was the problem, nor even a lack of knowledge about the risks of transmission and how to minimize them. The problem was – as always seems to be the case in any don’t-ask-don’t-tell situation – knowledge itself.

Perhaps one solution to the problem of online attempts at serosorting is for hook-up sites to stop including that field in their sign-up pages. People can add the info if they choose, but including it in a menu of profile choices makes it seem as reliable as age, weight, or hair color (and of course, people never lie about those traits online). Barring that, a warning attached to each profile about the dangers of basing sexual decisions on a person’s claimed status might at least alert users to the dangers of trusting such info. It might even encourage more people with HIV to disclose before sex.

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Dating and Disclosing

by Jaszi Alejandro

In this day and age, with HIV being so common in the gay community, I would think that talking about your HIV status would be a normal part of dinner date conversation. But talking about it while dating can still be taboo and awkward. I know it can be for me, especially if the other person gets uncomfortably quiet when I bring it up, or is not very educated about HIV.

Sometimes, educating a date can be a fun, flirty, and even freaky experience. It can also be a headache. But dating in general is not easy for anyone nowadays. There are so many places to find people you may want to hook up with or date – where do you start? And when you throw being HIV positive into the mix, a whole other set of concerns arises.

Some big things to consider are the right time to disclose your status and whether or not it is better to date someone with the same HIV status as you.

After getting HIV in 2005, I got into a romantic relationship with someone who was HIV negative. It was the best relationship I’ve ever had. Since I had just been diagnosed, disclosure was my biggest obstacle. I waited a few weeks before telling him because I wanted him to get to know me first – but then I became eager to disclose because we were having deep feelings and I didn’t want him to find out from someone else. All my friends know I have HIV and it’s freely talked about in my social circle, but one of the worst things that can happen is having a potential partner find out from someone else that you have HIV. If that happens, he could get confused and might feel fearful and deceived.

So one low-key summer night, while hanging out in the living room, I got very serious and looked my potential new boyfriend deep in the eyes. My palms got sweaty and my leg started vibrating a mile a minute with nervousness. I told him my story, starting with how I met the person who infected me, taking him through the journey of that relationship and the lessons I learned, then disclosing my status, and ending it with my feelings of self-worth and how my life has changed since becoming HIV positive. I made it a point to let him know that whether he accepted me or not, I would be a strong person because I refused to think of myself as weak ever again.

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One summer night I got very serious and looked my potential new boyfriend deep in the eyes. My palms got sweaty and my leg started vibrating a mile a minute with nervousness. I told him my story, starting with how I met the person who infected me . . .

He accepted my truth, and luckily it was a bonding experience. I was so nervous, but I thought in my head, “If I truly care about this person then I should give him the choice of wanting to be with me without hiding any secrets about who I am – better sooner than later!” Even though being HIV positive is not all that I am, I definitely embrace it as part of who I am.

The relationship was wonderful. I patiently taught him what was safe and what was not, because it was important to me that he stay negative (which he did). By the time we separated, my status was not an issue at all. There were many other factors, and HIV wasn’t
the big concern anymore. He was a great support for me in learning how to take care of myself responsibly. That’s the cool thing about dating – it often times helps you grow as an individual.

It can be refreshing for people with HIV to date others with HIV because they don’t have to worry about rejection or fear. There’s less worry about infecting the other person, and that can increase intimacy.

Sometimes growth happens after a break-up. It’s not always an easy or pretty story for HIV-positive folks who try to have relationships with HIV-negative people. It can come with a variety of challenges, but I believe the power lies in how you handle those challenges.

Now that I am back in the dating world again, I do come across more fears when dating someone who’s HIV negative or of unknown status than I do when dating other positives. Important questions come up like: When’s the right time to disclose? Will he treat me differently? Will he think I’m leading him on if I don’t tell him on the first

continued on next page
Some people feel that people with HIV should only date other people with HIV, and that HIV-negative people should only date others who don’t have HIV, but that’s their opinion. It can be refreshing for people with HIV to date others with HIV because they don’t have to worry about rejection or fear. For me, there is a heavy weight lifted off of my shoulders when I’m dating and being sexual with another HIV-positive person. When I’m with someone who already knows he’s positive, we can relate to each other and bond in a way that’s very attractive, comfortable, and supportive. There’s also less worry about infecting the other person, and that can increase intimacy. I feel a different sense of freedom – I joke about my status and I let down my guard. Safer sex is still encouraged for HIV-positive couples because there’s a risk of re-infection (superinfection), which can lead to both people becoming resistant to one another’s HIV meds. But the fear of infection is not present when the relationship moves from dating to sex.

But some question the idea of “sticking to your own kind”. Could that be a form of internalized HIV stigma? Segregating yourself – dating only those who are “like you” – eliminates getting to know people for who they are inside and prevents you from exploring all your options in the dating scene. It’s often preached in our community that we should be able to fall in love with anyone regardless of race, class, gender, sexuality, or even HIV status. It’s definitely possible to date someone who doesn’t have the same HIV status, and to be very happy with that person. As I mentioned before, the best relationship I ever had was with someone who was negative. HIV-negative guys find me sexy – I can’t help it!

Disclosure is a part of letting the person you’re dating get to know the real person inside you, and getting to know the real person inside him. Whomever you decide to date, for whatever reasons, always remember that a person who is deserving of you will accept you for what you are and be willing to grow with you. Dating is not easy, but it is supposed to be fun and exciting above all. So don’t worry too much; just protect yourself throughout the process and protect your heart.
What would it mean for the future of the epidemic if HIV-negative people could take a pill to prevent HIV infection? That may soon become a reality: on May 10th, an FDA advisory panel voted 19 to 3 to recommend approval of the HIV medication Truvada as a prevention tool for men who have sex with men. The panel also voted 19 to 2 to recommend it for any HIV-negative person who is in a relationship with a partner who has HIV. The FDA usually follows its committees' recommendations, but is not required to do so. It initially said it would announce its decision on approval before June 15, but later extended the target date until September 14. The agency wants more time to look at the proposed medication guide, educational training, and the implementation system for the possible rollout of PrEP (pre-exposure prophylaxis). AIDS organizations nationwide are eager to hear the decision, since approval could transform the way we think about HIV prevention. In addition to condoms, safer sex education, and behavioral counseling, a new medical tool may soon be available.

Several studies have found that HIV meds taken daily by HIV-negative people can reduce their chances of infection.

A New Use for HIV Meds
HIV meds have long proved essential for helping people with HIV better manage the virus. The introduction of AZT in 1987 changed the course of the epidemic by prolonging lives and challenging the perception that AIDS was a death sentence. At the dose used back then, however, it was highly toxic and came with taxing side effects. The true breakthrough came in 1995 with the introduction of combination HIV therapy, a new approach to treatment that allowed HIV-positive people to lead healthier lives. Recent research has presented a new use of HIV meds: the "treatment as prevention" model. One study found that people with HIV are 96% less likely to transmit HIV to their negative partners when they start taking HIV meds earlier. But the use of HIV meds to prevent transmission has largely been limited to HIV-positive people up to this point.

So it comes as a major development that the FDA is currently reviewing an application for use of the HIV med Truvada as a prevention tool. Several studies have found that HIV meds taken daily by HIV-negative people can reduce their chances of infection. Some doctors already prescribe HIV meds as prevention, but since the FDA does not allow drug companies to market HIV meds
for prevention, these are known as “off-label” uses and are not covered by most insurance plans.

**The Evidence**

Over a million people live with HIV in the U.S., and an estimated 50,000 are newly infected each year. Recent studies focusing on HIV vaccines and microbicides (gels to prevent transmission) have produced disappointing results, and marginalized communities continue to bear the brunt of failed prevention efforts. People who are oppressed based on race, class, gender, and sexual orientation are at increasingly high risk for HIV, creating more complex challenges for prevention programs. Transmission rates among MSM are a particular area of concern. The CDC estimates that HIV infections among MSM increased by 34% between 2006 and 2009. They increased 48% among MSM of color during the same period. Thus, there is a sense of urgency among AIDS advocates that we need new prevention strategies.

Several studies have shown that PrEP is an effective prevention tool, including the “iPrEx” study, which was completed in November 2010 in Brazil, Ecuador, Peru, South Africa, Thailand, and the U.S. In this study, a total of 2,499 HIV-negative MSM and transgender women who have sex with men took either a daily Truvada pill or a placebo (sugar pill).

Researchers found that those taking Truvada were 44% less likely to become infected with HIV than those taking the placebo. Among participants who reported having unprotected receptive anal intercourse, which is higher risk for HIV, Truvada reduced infections by 58%.

PrEP could be most effective for people who have less control over condom use. A married woman who has difficulty advocating for safer sex with her husband could use PrEP if she suspects he has other partners. Researchers were unable to detect Truvada in the blood of the majority of study participants who took Truvada and became HIV positive. This means they might not have been taking the drugs as directed. In fact, adherence was surprisingly low. While people claimed an average of 90% adherence, blood tests indicated an adherence rate closer to 50%. On one hand, this opens the possibility that PrEP could be even more effective than iPrEx showed. On the other hand, adherence rates present a serious hurdle. If people in a closely monitored study have difficulty taking a daily drug, how can people be expected to take meds consistently in the “real world”?

In July 2011, the University of Washington released early results for its Partners PrEP study, which provided Truvada, Viread, or a placebo to 4,758 serodiscordant (one partner HIV positive, the other not) couples in Kenya and Uganda. HIV meds were found to protect the HIV-negative partners in the study from infection. Those taking Truvada had 73% fewer infections, while those taking Viread had 62% fewer infections.

Unlike the iPrEx study, Partners PrEP had a remarkably high level of 95% adherence to the pills, which might explain the higher success rates. These findings suggest that PrEP is safe and effective for heterosexuals as well as MSM, and that serodiscordant couples might be a realistic target population for PrEP.
But these studies leave many questions unanswered. Given the short-term nature of PrEP studies, what long-term side effects can arise for people taking PrEP indefinitely? Could PrEP protect injection drug users, who have not been addressed in any of these studies? What would adherence to PrEP look like without regular monitoring and behavioral counseling? How might PrEP affect women who are pregnant or using hormonal birth control? How do social factors like race, income, culture, education, and nationality affect adherence rates? And how do we pay for it?

The Cost

Some worry that PrEP would not be available to those who truly need it due to high price. There is no guarantee that Medicaid, Medicare, and private insurers would cover the cost of PrEP. Many people at risk for HIV are in low-income groups, and U.S. patent laws will block the availability of cheaper generic versions of PrEP.

Truvada can cost over $38 a day, while condoms cost under a dollar each. In meetings with clinicians and community advocates, Gilead has stated that the company has no plans to market Truvada for prevention. But if that changes, Gilead could make huge profits by marketing the drug not only to people with HIV, but to anyone at risk of being infected. PrEP might be available only for the wealthy, and not to those at highest risk of HIV infection. This would do little to address the social inequalities that make HIV prevention so complicated. And it would favor those who already have access to quality treatment while snubbing poorer people.

If funding is used to make PrEP more widely available, we face a challenge of how to use limited resources. Using the recently revised U.S. treatment guidelines that recommend HIV treatment for everyone with HIV, there are over 25 million people in the world who are in need of HIV meds but who do not have access to them. In the U.S. alone, over 3,500 people sit on waiting lists for HIV meds through the AIDS Drug Assistance Programs (ADAP). Can we justify investing in PrEP for HIV-negative people while the same drugs are unavailable to so many who need treatment? People with HIV in poor countries usually take cheaper generic versions of HIV meds, while people in the U.S. must pay more. A cynical cost-benefit analysis of Gilead’s potential profits might encourage it to market PrEP in the U.S., rather than increase the accessibility of HIV meds all over the world.

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number down to $85 billion. Over the next two decades, they estimated 490,000 new infections in the U.S. if PrEP is not used. But even if it is only 44% effective, 41,000 new infections would be prevented if high-risk MSM took the drug. They conclude: “PrEP in the general MSM population could prevent a substantial number of HIV infections, but it is expensive. Use in high-risk MSM compares favorably with other inter-

tentions that are considered cost-effective but could result in annual PrEP expenditures of more than $4 billion.”

“Even though it provides good value, it is still very expensive,” said Jessie Juusola, lead author of the study. “In the current health-care climate, PrEP’s costs may become prohibitive, especially given the other competing priorities for HIV resources, such as providing treatment for infected individuals.”

The Risks
Could a prevention pill prove harmful by giving people a false sense of safety? People might expect to be fully protected by PrEP and stop using more reliable forms of protection like condoms, which are inexpensive and 98% effective when used consistently and correctly. Though data from iPrEx and Partners PrEP are strong, they are not strong enough for advocates to consider PrEP a substitute for condoms. The appeal of a “magic pill” for HIV prevention might lure people looking for an excuse to stop using condoms.

More importantly, the iPrEx results show how difficult it was for people to take their pill every day, and how unrealistic it might be to ask a healthy, HIV-negative person to remember that without consistent support. Poor adherence threatens the long-term effectiveness of all HIV meds, with the virus more likely to build up resistance. Some MSM have reported buying HIV meds on the street and taking them only just before sex, thinking this will provide protection when there is no evidence to support that use. The illegal trade of HIV meds on the black market enables people to take them as PrEP without proper counseling, which can lead to drug-resistant strains. Without close monitoring, PrEP meds could enter the black market more easily and lead to more cases of improper use.

A few AIDS advocacy organizations have waged a campaign against PrEP approval, accusing the FDA of putting profits over safety. They claim that Gilead and the FDA have a close relationship and have worked to speed up the approval process. In early 2011, two Freedom of Information Act (FOIA) requests to obtain documents sent between Gilead and the FDA were filed, and the FDA denied both of them. There is concern that this could set a dangerous standard of pharmaceutical companies affecting public regulations.

AIDS advocacy groups argue that with the epidemic spreading at increasingly high rates among MSM, especially MSM of color, we cannot afford to dismiss PrEP as a potential tool.

Toward a Plan for PrEP
Other AIDS advocacy groups argue that with the epidemic spreading at increasingly high rates among MSM, especially MSM of color, we cannot afford to dismiss PrEP as a potential tool. The CDC estimates that 53% of new HIV infections occur among MSM. Condoms, behavioral counseling, and
social marketing have made a difference in some communities, but have not significantly slowed the spread of the epidemic in others. The rejection of any new strategy is a lost opportunity to prevent new infections.

High drug costs are real and devastating, but the dismissal of one request for FDA approval will not fix that problem. AIDS advocacy groups must work to reform drug patent laws so as to ensure the widest possible access to HIV drugs, notwithstanding opposition from drug companies. Cheaper HIV meds could save millions of lives, but wider availability of PrEP could save lives as well. Both approaches are compatible in a comprehensive approach to prevention. Following the FDA’s approval of PrEP, AIDS advocates should pressure drug companies and state Medicaid programs to cover PrEP at discounted rates.

**Recommendations**

Regardless of how we pay for PrEP, we must carefully implement this new tool to preserve scarce resources and ensure that no one thinks of PrEP as a miracle pill for HIV prevention. Advocates and healthcare providers should focus on the groups most vulnerable to HIV, such as MSM and women of color, in particular sex workers, serodiscordant couples, and MSM who have unprotected anal sex with multiple partners. This focus would be the most cost-effective use of PrEP. We must also ensure that health care providers monitor treatment and maintain close communication with people taking PrEP to minimize side effects and fight drug resistance.

We should also not regard PrEP as a replacement for current methods of prevention. Its use must be combined with behavioral interventions to ensure that people practice safer sex and adhere to their drug regimen. Perhaps creative use of technology could increase adherence, like a text messaging reminder service.

In communities where PrEP is introduced, advocates must continue to combat social inequality. Poverty and incarceration, for example, present real obstacles to safer sex and drug adherence. Testing services should reach out to entire communities to ensure that people with HIV become aware of their status and receive counseling on the benefits of HIV treatment—not only for their own health, but also to lower the risk of transmission. Health care providers need to focus on cultural competency with LGBT communities. This is particularly important for MSM and transgender women of color. Also, community organizations should address the potential stigma that might surround PrEP through counseling and social marketing.

Finally, clinical trials of PrEP should continue even if Truvada gains FDA approval, focusing on those most at risk. Injection drug users should be a priority, since no research is yet available on this group. Alternative forms of PrEP like injections, implants, and patches could address problems of adherence and should be studied.

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PrEP must be combined with behavioral interventions to ensure that people practice safer sex and adhere to their drug regimen.

PrEP could be a powerful tool in national and even global prevention efforts, but we are still far from a solution to the AIDS epidemic. AIDS advocates should support this new innovation, but hold institutions like the FDA and drug companies accountable if profit gets in the way of public health.

Liza Behrendt is a member of AVODAH: The Jewish Service Corps.
I was diagnosed with HIV when I was 13. So when I met Joe, I was worried about how he would react when I told him – he might leave all together. A prior relationship had ended up in total disaster after I disclosed. He told his ex-wife and she threw it in my face in a very vindictive way. He wasn’t as ugly about it as she was but said that he couldn’t carry on with someone who would “soon be dying an awful death.” I tried to salvage the relationship and offered support by answering his questions, but he wasn’t open to any of it. We parted ways and went on with our lives.

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When Joe and I started dating we always had safer sex, until after about three weeks he got sneaky and took off the condom without telling me. I didn’t realize it until after sex, so I asked him and he denied it. I felt he was not being honest and he finally admitted he didn’t like condoms and didn’t want to wear them. That’s when I told him that I was HIV positive and asked how that made him feel. He was very curious about how I faced the challenges of living with HIV. We talked for hours, cried, and held each other for the rest of the night. We haven’t let go since. It felt like a huge weight had been lifted off of my shoulders. He said it didn’t make any difference to him and that he would love me unconditionally. In fact he feels like we have a stronger bond now, because I have accepted all of his flaws now he can accept one of mine. We were married almost a year ago.

I have always wanted to practice safer sex but Joe absolutely disagrees. My doctor of course recommended the same but left the decision entirely up to us. I have always been a non-progressor and haven’t had the need to be on meds, except when I was pregnant with my daughter. But since Joe refuses to use a condom, I’m staying on the meds to lower the risk of transmission. We also discussed side effects of the medications and the need for me to see a doctor. Joe said it would set his mind at ease if I was in regular care. I felt the opposite, because I had always been really healthy and never needed much care. On top of that, I didn’t have health insurance. But luckily there are programs here in Colorado that help with drug coverage and provide health insurance to people with low incomes.

Joe has been tested but says like he doesn’t feel like getting tested anymore – although he will in the future. He says he feels closer to me now than ever and that he will always feel this way. He’s told me on a few occasions that I better not get sick on him.

But he has not told any family or friends, out of fear they won’t understand and will think less of us. He feels this is something the two of us are capable of dealing with ourselves and that with the amazing HIV drugs out today we can manage to live healthy and productive lives together. He has often told me that it’s he and I against the world and those who don’t like it can go somewhere...

When we decided to try and get pregnant, we chose to do it naturally because Joe thought it would be silly to do something like artificial insemination since we’re not having protected sex anyways. There wasn’t too much discussion with my doctor about it. He did talk with us about the risk factors and that the fact that I was on HIV medications lowered the risk of transmission. He also suggested that my husband get tested every three to six months. One doctor was a little surprised that I was the one who wanted to continue to practice safer sex and that Joe was the one who didn’t.
Having been in the HIV field for several years as a care manager and client advocate, I had gone through multiple trainings about HIV therapy. So I knew what precautions had to be taken and educated Joe about them. I did however bring him with me to a few trainings that the Children’s Human Immunodeficiency Program (CHIP) at our hospital hosted on how to go about getting pregnant and having an HIV-negative child. We looked up things online together, like information about the medications and their side effects. I signed up very early to participate in studies through the CHIP clinic that monitor my health, the growth of my baby, and the effects of drugs before, during, and after pregnancy, just as I had done while I was pregnant with my daughter ten years ago. So we didn’t have any issues with getting pregnant without condoms and didn’t feel the need to talk to other couples about their experiences trying to get pregnant.

Our sex life is still as strong as when we met two years ago. Of course with me being eight months pregnant, I am tired and physically drained, so sex is the last thing on my mind. Joe also feels like he may hurt the baby and is very nervous about becoming a father – he’s stressed about how he will perform once our son arrives. One concern that I know weighs heavy on his mind is whether our son will be HIV negative and healthy. We’ve both been counseled by the hospital staff and know that as long as my viral load remains undetectable our son will be fine, but there’s always a chance. My ten-year-old daughter is negative – she was born with Down’s syndrome and other health issues but HIV is not one of them.

We hope that our son, who is due on July 19th, will be born HIV negative and will live a long healthy life – we’re dedicated to giving our all to him.
Fortunately, people with HIV now have a number of options when it comes to pregnancy. Unfortunately, some of these options are often out of reach financially for many people. And they may face opposition from friends and family. A 2007 amfAR online survey of people in the U.S. found that only 14% of those between 18 and 44 felt that women with HIV should become pregnant, and a third of all respondents said they would not support that decision at all.

The “Women Living Positive Survey” included 700 women with HIV from across the U.S. When asked about pregnancy, 61% stated that women with HIV can have children if they have the appropriate support. But 59% also felt that society strongly urged them not to have children. In addition, 57% of those who became pregnant did not discuss treatment options with their provider before they became pregnant. They often found information online instead, which, as the post from “Margarita” below shows, can be risky:

“It is very possible to have a child while one partner is positive and the other is negative. As long as the negative partner

The results of PACTG Study 076, released in 1994, showed that HIV treatment could dramatically reduce (66%) the chance of an HIV-positive mother passing the virus to her child. Subsequent research and clinical practice have resulted in lowering that risk to less than 1%. In New York State, for example, the number of cases of transmission during pregnancy has declined from 97 cases in 1997 to just three in 2010 – a transmission rate of 0.7%.

Those odds are far more appealing, and the decision to become pregnant for people with HIV now focuses more on the issues that any couple faces: “Can I care for this child? Can I afford to raise a child? How can we get pregnant without harming our health, or the health of the person with HIV?” This last question is of particular importance for serodiscordant couples, in which one partner has HIV and the other does not. But even couples who both have HIV are often advised to always use condoms, to reduce the possibility of transmitting drug-resistant strains.
maintains an undetectable viral load, and you both lead a healthy lifestyle, i.e. exercise, proper diet, limit alcohol use and absolutely no drugs...even weed, the chance of infection is very low. As an alternative, think about purchasing a juicer! Try juicing fresh veggies and fruits to boost both immune systems. Kale, Carrots, Oranges, Blueberries, Cranberries...juice at least 3 times a week, you both will see and feel a difference.”

Clearly, a completely unproven statement like this needs to be discussed with a care provider. Many in the study had to make changes to their regimen after they became pregnant, instead of learning about their choices beforehand. In her presentation on the study at the Vienna International AIDS Conference in 2010, Dawn Averitt Bridge stated:

“We have laws in place in the U.S. that prevent fertility treatments for HIV-positive women. The assisted reproductive technologies are quite good but, unfortunately, not available to many women and men … And it’s a huge problem. Many of us chose not to have children many years ago, because we were either told we were crazy, or the risks seemed too high. And because people have gotten older, because you had long-term HIV disease, whatever the reasons are, fertility has become a very big issue and a big problem.”

The Ethics Committee of the American Society for Reproductive Medicine has stated that health care professionals may be legally and ethically obligated to help women with HIV who choose to become pregnant. They can refer patients to other facilities if they lack the expertise themselves, but a blanket statement of not offering care is no longer acceptable. In 2010, California mandated that all fertility centers provide appropriate fertility interventions to people with HIV or refer the couple to a center that offers such services.

Before You Start
The health of both partners should be evaluated and any problems should be addressed with their primary care provider. There are three different scenarios, and each one has unique issues and choices that affect the man, the woman, and the infant:

1. The man has HIV and the woman does not: this places emphasis on preventing the woman from being infected
2. The woman has HIV and the man does not: prevention of transmission to the man and to the infant need to be considered
3. Both partners have HIV: the emphasis is on preventing transmission to the infant as well as prevention of superinfection between the adults

(It’s important to remember that the infant can only acquire infection if the mother has HIV. If the father has HIV and the woman does not acquire it, there is zero risk of infection to the infant.)

In general, the partner with HIV should be taking HIV medication to ensure an undetectable viral load and raise the CD4 count as this decreases the risk of transmission in all three scenarios. If the woman is menstruating there is an increased risk of her transmitting the virus to her partner or for her acquiring HIV. For a man with HIV, there is likely a positive correlation between total sperm concentration and CD4 count. A 10-year study looking back at 181 men found that 42% had an abnormal semen analysis with at least one reading in the subfertile range. Fertility issues occur in both women and men with HIV. In addition, semen testing in men taking HIV meds has found a lower ejaculate volume, decreased sperm movement, and increased abnormal sperm. So some form of fertility testing for both partners may be a smart first step. After that, the couple must decide which of several methods to use.

Sperm Washing
This method protects either partner from getting HIV through sex. Most experts agree that HIV does not infect sperm cells. That makes it possible to use the sperm removed from the semen of a man with HIV safely. Two methods are most commonly used. In “density-gradient centrifugation” a sperm sample is mixed with a nutrient medium in a test tube and spun in a high-speed centrifuge. Sperm end up in the bottom layer of liquid and other cells which might be infected, remain in the upper layer. This method can be further enhanced by the “swim-up technique”. The washed sperm are placed in a petri dish and covered with culture medium (a liquid used to keep cells alive). Only the healthiest sperm swim into the medium, leaving other cells and HIV behind.

A 2007 study of eight sperm-washing centers in Europe, including over 1,000 couples, reported: “No female seroconversion occurred following treatment...allowing us to calculate the probability of contamination risk to be zero.” Overall, there have been no cases of a woman being infected with HIV in continued on next page
Having a Baby When You Have HIV  continued from previous page

over 6,000 cycles of sperm-washing reported to date. Each sperm washing cycle costs between $100 to $300, and pregnancy rates are 15-20% per cycle.

But at least six states have laws preventing the use of sperm from men with HIV in artificial reproductive techniques. Even in states without such laws, some clinics may refuse to provide services to people with HIV, but people should continue to investigate reputable health care facilities.

Artificial Insemination

Once the sperm have been separated from the semen, they must be placed in the vagina. Known as insemination, this can be done either by a doctor or at home. If done by a clinic, the cost is about $300 to $500 or higher per attempt. Since many couples can’t afford that, some do it themselves. Sometimes called the “turkey baster” method, this should be done when the woman is ovulating (ovulation tests are available without a prescription).

1. Get a plastic syringe from your doctor or buy the kind used to give medicine to babies. Draw back on the syringe once with nothing but air, then push the air out again. Now point the syringe into the sperm sample and slowly draw it back to suck in the liquid.
2. Get into a comfortable position, either lying on the bed with your bottom raised on a cushion, or on your hands and knees.
3. Either you or your partner slowly inserts the syringe as far into the vagina as possible. The area to aim for is high up in the vagina, toward the cervix.
4. Slowly squirt out the contents of the syringe and remove it gently.
5. Lie down for the next 30 minutes while the sperm make their way through the cervix. Some semen may leak out, but this is normal.

IVF

If you have difficulty in conceiving or if your partner has a low sperm count, couples can opt to try in vitro fertilization (IVF) together with sperm washing. IVF entails removing eggs from the woman and fertilizing them with the man’s sperm in the laboratory. The fertilized egg is then implanted in the woman. It’s considerably more expensive than insemination: over $6,000 per cycle. The success rate after sperm washing is about the same as it is for HIV-negative semen: around 12% for insemination and just over 30% for IVF.

Taking Off The Condoms

All of the above methods have been tested and are generally accepted by the medical community. But what about unapproved methods, like just taking off the condoms? This is the unspoken reality for many couples. Many doctors will not publicly discuss it due to the risk of transmission. In fact, one advocate with knowledge of this practice refused to be publicly interviewed for this article due to fears it would lead to his program’s funding being cut.

But couples certainly are doing this, as noted in this forum post from a man who identifies himself only as Mauro:

“I am HIV positive. My partner is HIV negative. We have two beautiful daughters. Both conceived naturally. Both, like their mum, are HIV negative. We initially considered sperm washing, but we would have needed to use artificial insemination. This was extremely expensive and involved travelling and giving my partner hormone injections. This was not the way we wanted to have a baby. We decided that the risk of transmission with someone who was undetectable for many years, extremely adherent and had no STIs was very low. So we bought a cheap ovulation test and did it naturally… and it worked… twice!”

“I think it is really sad that there are so many of us wanting to have a child so badly that we are willing to put ourselves at risk. I feel I am playing Russian Roulette with my life...”

An unnamed woman wrote this at thebody.com:

“My husband is positive, I am negative. I have contacted local labs to see whether they could help with sperm washing but have not had any luck. The only way is to pay over $3000 to send the sperm overnight to a facility that will process the sperm and check if it is undetectable and have it sent back, then an additional $10,000+ for IVF. Since this is not an option - next cycle I will use HIV meds and take my chances. I think it is really sad that there are so many of us wanting to have a child so badly that we are willing to put ourselves at risk. I feel I am playing Russian Roulette with my life and wish I could find an alternative solution to this.”

In Italy, Enrico Semprini was one of the first to promote artificial insemination for serodiscordant couples. But according to Pietro Vernazza, of Switzerland’s Cantonal Hospital, “about one third of the women who came for the first consultation would never show up for an insemination. And within Europe, all the centers have about one third no-shows – people who just don’t follow up. Semprini followed up with them. And among the 500 couples, 250 are parents now...We were sort of accepting that a major group was taking the risk and having unprotected sex. So we thought: It’s okay. The risk is very, very low. It’s probably in the range of one in 100,000, or one in one million. That’s about the risk that you take when you mount an airplane.”
To lower the risk as much as possible, Vernazza recommends these steps:

- Having unprotected sex only when the woman is ovulating
- Testing for STIs, which increase the risk of HIV transmission
- Ensuring that the positive partner is on a stable regimen with an undetectable viral load for at least six months
- Prescribing PrEP for the negative partner – usually Truvada (he has used two doses)

His study of 53 couples in which the man was HIV positive reported pregnancy rates of 50-75%, depending on the number of attempts. According to Vernazza, “It’s certainly better than with the insemination practice, where we reach 40%.” None of the women in the study were infected.

Much of the impetus for couples taking off the condoms comes from a study known as HPTN 052. It enrolled 1,763 couples (97% heterosexual) in which one partner, the man or the woman, had HIV, was not taking HIV meds, and had a CD4 count between 350 and 500. Half of the positive people in the study began HIV meds immediately, and half waited until the CD4 count dropped below 250.

The study was meant to run five years, but was stopped early due to the dramatic results. Of the 28 cases of HIV transmission in the study, 27 occurred in those who delayed treatment. That means that starting HIV treatment early reduced the risk of transmission by 96%. That’s definitely lower – but it’s not zero.

In Madrid, Pablo Barreiro looked back at 74 serodiscordant couples (52 with positive men and 22 with positive women). They were advised to have intercourse only when the woman was ovulating, and only after the partner with HIV had an undetectable viral load for six months. 75 children were born, and no cases of HIV transmission to the partner or child were reported. Studies have shown, however, that some men with undetectable viral loads still have HIV in their semen, so all were advised that the risk of transmission was not zero.

If both partners are positive, the only risk to the adults is being superinfected with the partner’s strain of HIV, which may be resistant to the meds the other partner is taking. If both partners are on HIV treatment and have undetectable viral loads, this risk is dramatically reduced. Both should be checked for STIs beforehand.

But there is still some uncertainty as to the risk of maternal HIV therapy, whether it be for treatment of her own infection or for PrEP, on the newborn, either early on or as that individual ages, and goes through different developmental stages. Some of this vagueness is due to the lack of long-term studies of the effects of HIV medications taken during the earliest stages of pregnancy on the newborn. It is also important to remember that the potential risk of toxicity to the newborn is greatest if exposure occurs during the first trimester of pregnancy. Unfortunately, most of the information concerning these risks is being collected through the Antiretroviral Pregnancy Registry (apregistry.com), which is voluntary and non-comparative.

Lastly, if the woman becomes pregnant and is HIV positive, it is important that she be followed regularly through pregnancy. Adherence is difficult, especially during the first trimester when nausea and vomiting are common and can be severe. Drug levels of many of the therapies are affected by pregnancy and may need to be altered at different times during the pregnancy. Optimal care is best done by a partnership with a knowledgeable clinician.

**Conclusion**

The bottom line is that having a baby when you have HIV is possible, but only safe when done in consultation with a medical provider who is an expert in this area. Simply taking off the condoms or attempting artificial insemination at home without medical advice is risky and often not effective. Discuss all your options with your care provider, clearly assess the risks, and use the approach that’s best for you.

Mark Milano is the Editor of Achieve
A Story of Magnetic Love

by Shannon and Tom Southall

Shannon:
Since I was diagnosed with HIV 20 years ago, my life has been an incredible journey – filled with joy, love, anger, and a whole array of emotions. One of the hardest challenges has been disclosing, not only to potential intimate partners, but to friends, family, and co-workers. At one point, I felt I just had to accept that God did not have someone in mind for me to spend the rest of my life with. But what’s that old saying? “When you finally stop looking it finds you.” Boy, did it find me! I can see that because of HIV I learned how to live my life – and that’s why I was ready for Tom when he entered the picture.

One of the things I learned was that the way people respond to my HIV status doesn’t have to do with me personally. They’re trying to figure out how they can deal with it. But accepting that is easier said than done, because rejection still hurts. I’ve decided that the only people I want in my life are those who fully support me. After telling potential partners that I had HIV and seeing them run screaming for the hills, afraid that I infected them by just holding their hands, or having them stay and then ending it myself because of their baggage, I resolved to always just say it up front.

When Tom and I started talking, I put it right out there. I knew to look at how someone responded. If he was completely on board with no questions, I was scared! If he couldn’t find the door fast enough, then so be it – don’t let it hit you on the way out. I live without shame – if you can accept me for who I am and what I bring to the table, let’s get to know each other.

I found that Tom’s baggage wasn’t any worse than mine and the relationship of my lifetime began.

When I told him, there was a pause and then: “Okay, what does this mean for us moving forward? What do I need to learn? How can we be together?” All amazing questions, and he ended with: “I want you in my life. I want to learn how to deal with this and how to incorporate it into our lives.” He was the first man to see me completely – not just my HIV.

I never felt I had to reassure him, but I have taken the time to continue educating him – not only about my life but about the community as a whole. In the beginning, I did have to reassure myself, though. I was always waiting for the other shoe to drop – for Tom to come to me and say he was sorry, but that after giving it a lot of thought this was just something he couldn’t do. It wasn’t until a year and a half ago that I finally realized he was “all in”, had both shoes firmly on the ground, and wasn’t going anywhere.

The first time we had sex, I’ll admit I was scared. I was so afraid he was going to change his mind and decide this wasn’t worth it. or that he would suddenly freak out and take the “forever shower” and scrub and scrub! but he didn’t, and over the years, the sex has gotten better. Our lines of communication are wide open and we are able to talk to one another throughout sex. We even laugh and then stop and say, “Are we supposed to be laughing during sex?” Yes, because we enjoy one another so much.

After telling potential partners that I had HIV and seeing them run screaming for the hills, afraid that I infected them by just holding their hands, I resolved to always just say it up front.

I’m actually more careful during sex, because if Tom were to become infected I’m not sure how I would handle it. He says if it happens, it happens, but we know what we need to do to protect him. Sometimes, I’ve even had to play “HIV cop” to make sure that no matter what we experience, Tom is safe.

Eventually, we decided that my undetectable viral load and the fact that I am a woman lowered his risk enough that we could take off the condoms. That decision is not for everyone, and each couple needs to make an informed decision after talking to their doctor. If my viral load was detectable, safer sex would definitely be required. I will say that the first
time we opted not to use a condom was an anxious moment for me. But we educated ourselves, we talked to experts, and did research. So we both felt comfortable with the decision.

Apart from sex, we both have to deal with me sometimes feeling sick and having side effects from the medications. And then there are the plain old issues that affect any relationship: finances, kids, jobs, family, communication. I had surgery and developed a staph infection. I had to have a second surgery, keeping me out of work for four months. Things like that can spiral me down into what I call a “mini depression”. I always know I will get out of it, but I get scared and withdraw, which affects our relationship.

Of course, disclosing to your partner isn’t the end of the issue. I’ve told everyone in my life, but telling people in Tom’s world has been in a different time frame. We told his sisters and brother and slowly word got out, but no one treated me any differently. We told his sons a few weeks before our wedding and found out that his ex-wife had already told them without mentioning it to us! So they just said, “Yeah, we’ve known for a while.” I was even more impressed that they knew and never mentioned it nor treated me any differently. After we were married, I was interviewed by a local news station and Tom called his buddies so they wouldn’t learn about it on the news. They have all been extremely supportive.

Until I met Tom, my life literally revolved around HIV. I was the Executive Director of a not-for-profit that worked with women living with HIV. I never really had a break from HIV. Tom is a sports enthusiast, and he helped me rekindle my love of sports. I’m now a high school volleyball official and a track and field official. We travel all over, officiating disabled sporting events – in fact, Tom first told me he loved me on the Great Wall of China, when we were there for the 2008 Paralympics.

I have been extremely blessed. Before I met Tom I appeared in a local video and said that I would never give up on eventually finding my Scarecrow, since “The Wizard of Oz” is my all-time favorite movie. Tom is my scarecrow! My favorite Broadway show is “Wicked” – in that show, Elphaba feels no one could love her because she’s different. Finding someone who is able to look at life differently, look at me fully, and love me completely is the greatest blessing I could ask for.

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**Personal Perspective**

A Story of Magnetic Love  continued from previous page

**Tom:**

I had never dated anyone with HIV before, and I found out about Shannon before we started dating. We had exchanged emails after I found out about a fundraising event her agency was having. Shannon told me in her first email that she started the agency and did so because of her own status. She experienced first-hand the lack of services for women with HIV in Colorado and did something about it.

I hadn’t thought about getting involved with anyone, but then I saw her at the fundraiser. As the night went on, the more time I spent with her the more I was drawn to her. We had a lot of common interests, especially sports. We’re both highly active in the areas of social change. She has a fantastic sense of humor, dignity, and pride – and she’s beautiful. So when I put all of that together I knew the HIV was not a deal breaker – it was something we would discuss. I would learn to handle it and deal with it in a responsible and respectful manner. I lost my brother to AIDS in 1996, and that’s allowed me to be empathetic and open to people living with HIV.

The first time we had sex, I was nervous and excited like anyone is. We knew what precautions to take and were prepared because we had had the conversation beforehand. I trusted her knowledge and expertise and that she would not put me in a situation that was unreasonably harmful or unsafe. Over time, it continues to get better.

The first time we had unprotected sex was right after the Swiss study came out, which found no infections in “magnetic” couples in which the partner with HIV had an undetectable viral load. We talked about the study and what that meant for our relationship. Shannon’s adherence to her medications and appointments, leading her to having an undetectable viral load, led to us having unprotected sex for the first time. I have never felt fearful of becoming HIV positive.

I’m mindful of Shannon’s health and ensure that she stays as healthy as she can. She knows her body and her health, and I have to be active in helping her main-tain it. Our lives can be very stressful, and making sure that she has downtime is crucial to not only her physical health but her mental health as well.

The only time Shannon’s medications affect our relationship is when she has difficulty getting them filled or forgets to bring them along. I specifically remember a trip a few years ago to Vancouver when she forgot her medication and we had to drive across the border to Washington to get her prescriptions filled. Now I make sure that her medications are on our packing checklist!

Shannon recently was in the hospital, and her door was marked to let the staff know that she had HIV and to take precautions when in the room. That made me angry, knowing how far we have come but being shown in an instant how far we still have to go. I am glad how far society has come in being informed about HIV, but it’s frustrating to see pockets of misinformed people – especially in the medical field.

Over the years I have been telling friends and family, Shannon had always told me that it was up to me when to tell my two sons. She came to me a few weeks before our wedding and asked that we tell the boys – everyone in her world knew and she wanted the boys to know. But we haven’t told many of my casual friends or acquaintances. It isn’t a priority for us. We’re not hiding it. Who knows? They may already know – it just doesn’t affect those relationships.

Our only bad reaction came when my ex-wife did an internet search on Shannon and found out about her status. She told my sons before Shannon and I had a chance to. I am so proud that my sons didn’t freak out or react badly in any way. But everyone who is active in the community or has HIV associated with their name probably knows that if someone searches for them on the internet they can find out your status.

I’ve learned that love takes different forms. It can be shown in different ways and experienced in different ways. The power and the will to overcome problems must be shared – it’s not an individual endeavor. I’ve learned that falling in love with someone’s soul and inner spirit is a much deeper experience than I could have ever imagined. Finally, I’m proud that Shannon works with people living with HIV and allows them to see that there is life after diagnosis. She continues to amaze me with what she knows and how she’s able to teach others about HIV. She has truly taken lemons and made lemonade. ■
On May 24th, Queerocracy, a New York City grassroots organization, held a community forum on HIV criminalization at the LGBT Center. Entitled “Prosecution vs. Prevention”, it highlighted the many abuses the U.S. criminal justice system applies to people with HIV. With the underlying message of “HIV is not a crime”, several panelists spoke on the work they do and their relationship to the HIV-specific criminal laws that many states have.

Panelists included Adrian Guzman from The Center for HIV Law and Policy, Sean Strub from the SERO Project and the Positive Justice Project, Christina Rodriguez from SMART Youth, and Robert Suttle, who was incarcerated in Louisiana for HIV non-disclosure.

Know Your Rights

Adrian Guzman provided an overview of the issue, New York State criminal laws that target people with HIV, and what to do if arrested. He noted that dozens of states have HIV-specific criminal statutes, and nondisclosure is frequently an element of the crime. Two types of behavior are most commonly targeted: spitting and biting (usually specific to police and prison officers) and sexual contact (the type is rarely specified). In most cases, transmission is not necessary—“exposure” without disclosure is enough. Often the only defense is to state that disclosure did occur prior to sex, but that can be difficult if not impossible to prove. The actual risk of transmission (type of sex, condom use, low viral load) is rarely considered in determining intent to harm or whether prosecution is appropriate. In fact, wildly inaccurate beliefs about the actual risks of HIV transmission seem to inform these laws.

Of particular interest was the disparity in sentencing requirements: in Georgia, for example, someone convicted of not disclosing HIV status before sex faces up to 20 years in prison, whereas someone convicted of vehicular homicide in the second degree faces up to one year in prison and/or a fine of up to $1,000!

Most laws were passed in the 1990s, when HIV was considered fatal. In order to qualify for HIV funding, the Ryan White CARE Act initially required states to demonstrate that they were able to prosecute cases of intentional HIV transmission. Most of today’s laws, however, are based on inaccurate beliefs about the actual risks of HIV transmission, and even criminalize actions like spitting that cannot transmit HIV. (Fortunately, New York State’s highest court ruled on June 7 that the saliva of a person with HIV cannot be considered a “deadly weapon”.)

In New York State, HIV-positive people are targeted using general criminal laws, including reckless endangerment and aggravated assault. At least one court has allowed access to a defendant’s medical records to prove whether she was HIV positive.

“Disclosure Is Hard”

Christina Rodriguez, who was born with HIV, told her story:

Until I went to college, I never had to actually tell anyone I had HIV. It always seemed to be done for me: in magazines, newspapers, documentaries, etc., since my mother was a well-known HIV advocate. I had never gotten a bad reaction, but this was a whole new world – college students on a small campus. On top of being a freshman, I was stressing out about disclosure. Who would I tell? When? How?

But these concerns were just a fraction of the anxiety I endured when I finally disclosed to my friend of seven years. We hadn’t spoken in a couple of years and I decided that when he came back to New York I would tell him everything. I couldn’t sleep. I couldn’t eat. My heart raced at the thought of the moment I would tell him.

On the day we met, I remember that everything seemed to slow down. I could hear my heart in my ears. Everything went quiet. I was sweating in a fully air-conditioned car. I wanted the world to

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swallow me whole. What did I get myself into? Should I just turn back home?

But I pushed through. I looked everywhere but at him as the topic started to emerge. I took out flashcards I had made to help me keep track of where to start and how to end. Once I couldn’t think of anything else to say, we sat in silence. It was the longest, most awkward moment of my life. I prepared myself for the worst – if he wanted me to leave, I would understand. I would take care of whatever emotions I had in the comfort of my own home. But he didn’t, and we’re still together. I’m extremely lucky to find someone so understanding and willing to become educated.

The moral of the story is that disclosure isn’t as easy as people make it out to be. You can’t just say, “Tell people, tell people, tell people.” Not everyone is in as stable place as I am. You can’t expect people to say things so easily, especially when there are laws out there that can put someone in jail just for being HIV positive. We need education and support – not more stigma. Not to be labeled as “weapons of mass destruction”. We are human beings, and disclosure is hard. These laws are not providing the right message in order to move forward.

Serving Time

Robert Suttle then shared his experience:

I am not a criminal. I am not a sex offender, but the state of Louisiana says that I am. I am the oldest of six children, and my grandparents instilled in me faith, discipline, and personal responsibility. After college, I tried to join the Air Force, but during my physical I discovered I had HIV and was not allowed to serve. So I began work as an assistant law clerk, and was well on my way to becoming the first black male deputy clerk in the Louisiana Second Circuit Court.

But after five years, that budding career – and life as I knew it – abruptly ended. A former partner from a contentious relationship filed charges against me for not having disclosed my HIV status when we first met. This wasn’t about transmitting HIV – just whether I had shared my HIV status. How do you prove that you told someone? I couldn’t. So I accepted a plea bargain rather than risk a ten-year sentence. I served six months and am now required to register as a sex offender for the next 15 years.

When I was released from prison, I knew I had suffered a terrible injustice, although I didn’t know it had a name: HIV criminalization. I wanted to become an advocate and help create a movement to correct the injustice. That’s when I found Sean Strub, who helped get me involved in the global movement to stop the criminalization of people because of the viruses they have. Last December I went to Switzerland to speak before the UNAIDS Programme Coordinating Board, and this past February we went to Norway where I spoke at the U.N. High Level Consultation on HIV Criminalization. I’m determined to do whatever I can to prevent anyone else from suffering a miscarriage of justice like mine.

I don’t understand why the gay community and the AIDS community are not talking about this. It feels like we’re ashamed of it. I think criminalization is not the answer to HIV prevention. Just because you know your status, the law says that is intent. People with HIV have a right to have sex. Everyone deserves that. We’re human beings

I talk about this because I have nothing else left. I want to see things change. I want to see people with HIV hold their heads up high and not be ashamed of a disease they did not ask for. Please take what you learn here tonight and use it.

A Community Discussion

The panel then opened up the discussion to the floor for questions and comments (in italics).

I’m hearing two different things: one, that you can be arrested for not telling your partner, and two, that in some cases people have been arrested even after they disclosed.

Robert: That’s the problem: how do you prove that you told someone? 

Sean: Sometimes people are prosecuted because they didn’t disclose immediately, even though the relationship went on for some time after disclosure. Some people are afraid to disclose because what someone from their past, or even someone they met before they knew they were positive, might report them.

Were states too hasty in getting rid of written consent and counseling?

Adrian: There’s a conflict here: the public health community says written consent is a barrier to testing. Human rights advocates say it is not a barrier and we need it. The elimination of written consent and the information necessary to make sure consent is informed have been the main issues in the debate, and until recently criminalization has not received as much attention.
Arguments against HIV Criminalization

- Penalties vastly disproportionate to actual risk or harm
- Has little or nothing to do with actual risk
- Treats HIV differently from other STIs that can also cause serious harm
- Discourages disclosure – fear of someone from the past coming forward
- Contributes to the spread of HIV by driving stigma and discouraging testing – ignorance of your HIV status is the best defense
- Creates a “viral underclass” – different laws for people with HIV

My comment is that I think there’s a tremendous danger in focusing on eliminating disclosure requirements – that’s a brick wall. It will create a rebuttable presumption: “Of course this guy didn’t disclose – no one ever discloses.” The community needs to come up with a strategy that won’t run headlong into the right wing. I fear there might be some naivety here about just how bad the stigma against people with HIV is. “Take the test and risk arrest” could push further actions like we’ve seen in France, where there have been prosecutions based on the idea that you should have been tested: “We think you avoided being tested because you didn’t want to know.” I have seen positive people discuss this issue in ways that seem to me, as a positive person, pathological about their lack of obligation to disclose.

Sean: You’re talking about a core issue: what is the obligation to disclose? The Global Network of Young People with HIV has put out a paper where they assertively affirm the right not to disclose. This is very controversial – I’m not sure where I stand on it. We still don’t have a consensus as to the role of the courts regarding sexually transmitted pathogens that can cause serious harm if left untreated.

But I am sick of what I call “the arrogance of the well”. The assumption that there’s a pristine, perfect healthy person out there and it’s my job to protect him or her – that we, people with HIV, are inherently a danger to them. The substance of what establishes a moral obligation to disclose is being defined by people who don’t have HIV. But it’s equally dangerous not to acknowledge that there can be a harm inflicted when someone does not disclose – sometimes even when there isn’t HIV transmission. There’s harm in deception, for sure, and there can be harm in failing to volunteer relevant information, even in the absence of deception. The obligation to disclose is different in different circumstances and it’s very difficult to translate that into law.

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I wish we could all sue someone for lying to us. Half the people on Manhunt.com would be in jail! When is a person criminally liable for a misunderstanding or even a complete fabrication? It seems like the people in greatest danger are those who were in relationships, did disclose, and it ended badly. Someone could be criminally prosecuted because someone didn’t like the divorce settlement! Do these people have access to lawyers?

Adrian: Many of the people who are being prosecuted are those who can’t afford attorneys. Many people also mistakenly think that a lawyer they pay for is always better than the public defender. The Center for HIV Law and policy has built a network of lawyers around the country who, depending on the case, may be able to help someone facing arrest. In New York City, there are a lot of attorneys and other advocates who provide legal services to people with HIV, but that’s not the case around the country. When you’re facing criminal charges, you need a criminal defense lawyer.

Sean: Most people I know who got prosecuted did not have very good counsel. A lot of people have been convicted because they were more cooperative than they should have been. If it comes up, shut up – you need a lawyer. People have said things in the moments after being arrested that caused big problems later on.

Being in a serodiscordant relationship, I’m feeling paranoid right now. I can’t be open with my partner’s family because they live outside of the country. This is a pink flag for me – I know my partner, but can I trust him in the future? It’s scary that we’re still having this conversation. It sucks big time.

Adrian: So many of the HIV-specific criminal laws – and even the laws that are not HIV specific, like those used in New York – are being used against people with HIV, causing them to live in fear and think that the only way to protect themselves is to criminalize nondisclosure. But it’s really our own behaviors that protect us the most.

If this is a part of the Ryan White CARE Act, why are we going state by state or city by city? Mayors and governors have no control over Ryan White requirements. Let’s go to Congress and have that law revised.

Sean: Actually, the reauthorization of Ryan White deleted this requirement a number of years ago. The states passed these laws years ago and they’re still there. So our approach is on multiple levels: first, there’s the community approach and education, then we approach the individual states, and there’s a federal approach and a global approach. Whether one will work better than the others, we don’t know.

Do young people know about this?

Sean: When I speak on campuses I am appalled by how little they know about transmission. Polls show that 79% of gay men aged 18 to 21 support criminalization of HIV nondisclosure. There will be a paper at the International AIDS conference this summer showing a correlation between confidence in HIV statutes and a willingness to engage in unprotected anal intercourse. The more you believe criminalization is protecting you, the more likely you will put yourself at risk. That’s part of the growing body of evidence that criminalization is contributing to transmission.

One African-American minister said, “HIV is always dicey to talk about in our churches – but we understand putting black men in prison.”

What’s the strategy?

Sean: The Positive Justice Project has a working group that is talking to public health officials. The National Association of State and Territorial AIDS Directors came out with a terrific statement on this, and the President’s HIV/AIDS Strategy includes a great paragraph on criminalization that opened up all sorts of conversations with federal agencies. There is a process under way to develop a community consensus statement. But this is going to be difficult work. It’s a movement in its beginning stages. A friend told me, “You’re one of those lost cause people.” But in the last two years we’ve come farther than I ever thought we would. It’s not a lost cause.

Adrian: Changing laws is difficult. Law is often based on precedent – it takes a very brave court to break free from tradition and take a stand on what we think is a more commonsense approach. In some states, judges have actually ordered a defendant to take an immediate HIV test – the defendant leaves the courtroom, takes a rapid HIV test, comes back 20 minutes later, and is forced to share the result. And changing the laws on the books takes legislators with political will and courage. Mobilizing people at the grassroots level and from all the relevant professions – medical, public health, law enforcement – can provide well-intentioned legislators with the support they need to make change. There are people organizing in at least half a dozen states, and PJP is providing the support to keep that moving forward.

Are any repeal efforts under way?

Sean: Legislation was introduced in Iowa two years ago. There’s a woman with HIV leading the effort. The Iowa Public Health Department – in a state with a Republican governor – has been quite cooperative. One of our efforts has been to develop this effort without making it a Republican/Democrat issue. In other states, a few meetings have been held, so it’s just beginning.

Last year, Barbara Lee, a congresswoman from California, introduced the Repeal HIV Discrimination Act that requires the Pentagon, the Department of Health and Human Services, and the Department of Justice to review federal laws and regulations to identify where they place “unique or additional burdens” on people “solely as a result of their HIV status” and encourages their repeal. So far, it has 30 cosponsors.

Conclusion

The forum ended with a call to action. Adrian noted the many materials available at the Positive Justice Project website, and urged people to spread the word about the National Convening on HIV Criminalization, being held on July 20th in Washington, D.C. People can also visit thistigmaproject.org.
Sexuality is an integral part of human identity. A healthy sex life may include relationships that evolve into friendships and sometimes lifelong commitments. And it can contribute to happiness, confidence, and pride. Yet persistent stigmas surrounding aging and HIV often limit the opportunities for sexual expression among older adults, especially those with HIV. When combined with other stigmas, such as homophobia, transphobia, or racism, it’s a wonder that many ever get out of their beds, much less into someone else’s!

Persistent ignorance and prejudice contribute to many older adults with HIV being afraid to speak openly about their sexuality with their physicians and services providers, who too often, perhaps unwittingly, exhibit biases of their own. For an older adult with HIV who wishes to enjoy a full life that includes a healthy sex life, persistent and pervasive stigmas can lead to social isolation, depression, and self-esteem issues. And they can create other challenges like failing to practice safer sex consistently.

People with HIV of every age face tremendous disclosure challenges in sexual relationships. Widespread myths that fuel HIV stigma lead some to conclude that people with HIV are a public health danger and shouldn’t be having sex at all. Facts relating to safer sex, treatment that leads to undetectable viral loads, and other prevention methods are ignored. Worse, where HIV is criminalized, people with HIV are effectively banned from having sex if they aren’t prepared to disclose, no matter their sexual behavior or the level of risk, and are frequently prosecuted even when they do.

Notwithstanding the challenges and pervasive myths (including that older adults are either monogamous or asexual), there is substantial evidence that many people remain sexually active well past age 50, and often with multiple partners. And, like others, older adults have unprotected sex. But unlike virtually all other at-risk populations, there are very few HIV or STI prevention interventions targeted to those who are in middle age or beyond. For a host of reasons, many older adults have drastically different experiences with and perceptions about HIV than their younger counterparts, including the belief that they are less at-risk than others.

What to do? Here’s a short and smart advocacy and policy agenda for leaders in the U.S. and around the world:

• **Testing:** Make HIV testing of adults routine without regard to age. It is time to modify the CDC’s recommendation, which presently ends routine testing at age 64. It is both cost effective and sensible public health policy to test all adults routinely. This change alone could encourage more providers, and older adults themselves, to initiate useful and instructive discussions about their sex lives and, as a result, conversations about HIV and STI prevention.

• **Research:** Fund targeted research, particularly among older men who have sex with men (MSM). Although one in six new HIV diagnoses in the U.S. is among older adults (a rate that is steadily increasing), there is a gross lack of data and information about older adult sexuality, particularly that of older LGBT adults. We very much need this information to more effectively design strategies that target HIV and STI prevention for older adults, especially older MSMs.

• **Training:** We can’t lessen, much less eliminate, the impact of HIV stigma and ageism if we don’t educate providers – from physicians and nurses to social workers and case managers – on the scourge of multiple stigmas. And we can’t hope to end this epidemic if those most at risk won’t approach providers and remain engaged in services because they feel unseen, unwelcome, or misunderstood. It is well past time to stop behaving as though older adults aren’t having sex. Funding training for all health providers on how best to initiate conversations about the sex lives of their older adult patients, especially MSMs, without reinforcing silence and stigmas is vital. And cultural competency training at the intersection of HIV, ageism, homophobia, transphobia, racism, and sexism can make a genuine difference in the quality of the services they deliver.

• **Education:** Of course, the corollary to training for health providers is targeted educational materials for older adults themselves, including funding for widespread and engaging social messaging campaigns on HIV and STIs that include prevention messages.

Aging is challenging – as is living with HIV – but it doesn’t have to be. A coalition of advocates, public health agencies, and service providers must work to ensure that older adults, regardless of their HIV status, are able to age gracefully, soundly, and healthily. And that includes having exciting and healthy sex lives!
ACRIA at the 2012 International AIDS Conference

ACRIA will have a major presence at the Conference being held in Washington, D.C. from July 22-27. In addition to its booths, “International HIV and Aging Resources” (booth 74 in the Exhibit Hall) and “The Graying of AIDS: Portraits from an Aging Pandemic” (booth 959 in the Global Village), ACRIA will be involved in the following presentations:

- **MSM Global Forum Pre-Conference:** “Decreasing HIV-related stigma, homophobia and ageism” – Saturday July 21, 8:30 am - 5:00 pm
- **Satellite presentation:** “HIV and Aging: a Global Perspective on Research, Care and Prevention” – Monday July 23, 6:30 - 8:30 pm, Session Room 6
- **Satellite presentation:** “HIV and Aging: The Challenge of the Epidemic’s Fourth Decade” – Wednesday July 25, 6:30 - 8:30pm, Session Room 7
- **Poster:** THPE558 “Developing an HIV/STI prevention intervention targeting older adults living with and at risk for HIV” – Thursday July 26
- **Poster:** THPE559 “Sexual Event Characteristics among Gay and Bisexual Older Male Adults in the U.S.” – Thursday July 26

End HIV Criminalization!

A CALL TO ACTION

In at least 39 states, people with HIV have been charged under HIV criminalization laws. This often affects their ability to find housing and employment for the rest of their lives. These laws make HIV transmission a crime, but charges are often filed for actions that are almost impossible to transmit the virus, like spitting or biting. Worse yet, these laws only apply to those who know they are positive, which discourages others from getting tested.

The REPEAL HIV Discrimination Act, HR 3053, would require a review of laws that criminalize HIV transmission. States would then have to issue a report explaining those laws in the context of current scientific knowledge and comparing them to similar laws for other diseases. This legislation could go a long way toward repealing such discriminatory laws.

Call your U.S. Representative at 202-224-3121 and ask them to support HR 3053. Living with HIV should never make someone a criminal, and federal law should reflect this and promote effective public health policy.